University of Alberta

What Is Values-Based Leadership?

by

Karen Macmillan ©

A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of
Master of Nursing

Faculty of Nursing

Edmonton, Alberta
Fall 2007

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Ottawa ON K1A 0N4
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Your file Votre référence
ISBN: 978-0-494-33182-8
Our file Notre référence
ISBN: 978-0-494-33182-8

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Dedication

To my husband, best friend, and confidant, Andrew, for the encouragement, support, confidence, and inspiration in helping me to achieve my goal.

To my children, Nikolas, Kira, and Jeremy, who always believed in my abilities and reminded me to do my homework.

To my parents, Joseph and Lydia, who were my biggest cheerleaders and never gave up faith in me.

To my friends, mentors, and colleagues, who taught me what it is to be a leader.

Abstract

Values-based leadership is a term in the leadership literature that describes how leaders and organizations build trust and credibility with staff and the community by being accountable for identified values (Martin, 2002). Health systems leaders in Saskatoon, Saskatchewan, were faced with financial challenges as they implemented a provincial policy to regionalize all health services under regional boards. A partnership agreement signed in 1996 between St. Paul's Hospital (SPH) and Saskatoon Regional Health Authority (SRHA) was an unprecedented change strategy that restructured the delivery of healthcare in the community. In 2005 both organizations reaffirmed the partnership agreement and the integrated management structure that was developed to implement it. It is therefore of significant interest to explore and describe the leadership characteristics, behaviours, and leadership styles of past and present leaders in SRHA and SPH who designed, implemented, and sustained this change. These behaviours and characteristics were explored using themes that operationally define values-based leadership.

Acknowledgements

There are many people to whom I wish to express my gratitude and thanks. I thank Dr. Sharon Warren, for her guidance in my methodology; and Dr. Greta Cummings, for her expertise in nursing leadership research. A special thank you to Professor Donna Lynn Smith, who inspired me to explore the area of leadership, helped me through the rough spots, and never doubted my ability.

Mary Pat Skene first introduced me to the idea of values-based leadership and encouraged me to look at the model of care in Saskatoon.

I am grateful to all of the leader informants who took time out of their busy schedules to share their experiences with me. What a wonderful learning opportunity!

I want to acknowledge the Caritas Health Group and my supervisor, Greg Hadubiak, for financial assistance and time to complete my course work.

I also want to acknowledge the financial support and funding from the LINCS Research Program led by Professor Donna Lynn Smith and funded by the Canadian Health Services Research Foundation and the Alberta Heritage Foundation for Medical Research.

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CHAPTER ONE:

INTRODUCTION

Leadership is one of the skills that organizations and business today most desire and value (Leatt & Porter, 2003; Storch, 2006). Nursing leadership has become increasingly important because of ongoing changes in the health care system and the challenges of limited financial and human resources (Storch, 2006). Most definitions of leadership include elements of people as well as groups. *Values-based leadership* is a term that appears in the leadership literature that describes how leaders and organizations build trust and credibility with staff and the community by being accountable to identified values (Martin, 2002).

According to *Webster's Ninth New World College Dictionary* (1996), *values* refers to the "social principles, goals or standards held or accepted by an individual, class or society" (p. 1474). Values are part of an individual's conscience and worldview and provide a reference point or guide for decisions and behaviours. An individual's system of values affects his/her actions and choices. Organizations also have values that are expressed through written documents such as mission statements and the behaviour of leaders and others to create the culture of the organization.

Values can provide a guide in everyday decision making and give additional purpose and meaning to work life for all staff. Individuals develop a sense of satisfaction when they work toward achieving values that they believe are important. Values encompass the abstract of what is right, worthwhile, and desirable. Shared values among the leaders and staff are the building blocks that create inspiration for staff and help the organization to fulfill its aspirations (Secretan, 2004).

Purpose of the Study

The purpose of this study was to explore themes that operationally define values-based leadership. This exploratory descriptive study was a substudy within the LINCS (Listen, Innovate, Navigate, Connect, and Share) Research Program, which was funded in 2003 by the Canadian Health Services Research Foundation and the Alberta Heritage Foundation for Medical Research, with research partners in Alberta and Saskatchewan. Semistructured interviews conducted for the LINCS program were designed to identify contextual factors and leadership approaches related to specific service integration strategies in two metropolitan health regions, one in Alberta and one in Saskatchewan. In the interviews the informants were asked questions about the behaviours, characteristics, and leadership styles of senior leaders in the Saskatoon Regional Health Authority (SRHA) and St. Paul's Hospital (SPH). One former leader in Saskatoon used the term values-based leadership to describe the development and implementation of an innovative and collaborative partnership agreement between SRHA and SPH.

A secondary analysis of the LINCS interview data was conducted for this thesis research. The 15 interviews conducted with senior officials of the SRHA and SPH were examined for themes derived from a review of the literature on values-based leadership.

Research Questions

The study was guided by the following questions:

1. What are the leadership characteristics, behaviours, and values of the past and present healthcare leaders in Saskatoon who developed, implemented, and maintained a partnership agreement between St. Paul's Hospital and Saskatoon Regional Health Authority?

2. Do these characteristics, behaviours, and values suggest a leadership style?

The following three questions in the semistructured interview guide (Appendix A)were directly pertinent to the two research questions above:

- How did leadership characteristics and behaviours and values impact the planning of the agreement?
- How did leadership characteristics and behaviours and values impact the implementation of the agreement?
- What kinds of values and leadership characteristics and behaviours do people need to be able to work in this structure?

Research Context

The SRHA provides health services to approximately 300,000 people, 73% of whom live in Saskatoon (Saskatoon Health Region, 2004). Saskatoon has three acute care facilities, the Royal University Hospital (RUH) and Saskatoon City Hospital (SCH), both owned by the SRHA, and SPH, owned by the Saskatchewan Catholic Health Corporation (SCHC). A formal partnership agreement between SRHA and SPH was created in 1995 to address the health needs of the population in and around Saskatoon, Saskatchewan. This partnership agreement was implemented through an integrated program management model.

In 1992 Saskatchewan became one of the first provinces to create regional health authorities, thereby eliminating all hospital, nursing home, and public health boards and combining them under regional boards. The regional board became responsible for all public health organizations with the intent to control costs by eliminating duplication and inappropriate resource utilization and an intended result of improving continuity and accessibility to care (Jacobs, 2006). The province distributed money for delivery of healthcare to the regional health board, which, in turn, funded the privately owned and voluntary facilities. Examples of voluntary facilities are religious organizations that own and operate faith-based facilities but depend on public funding for capital and operational costs. Prior to the regional changes, these organizations dealt directly with the government. At the time of regionalization, the new regional board became responsible for the governance and administration of all publicly funded health organizations, including private and voluntary health organizations. The regional health authorities signed affiliation agreements and formed a contractual relationship with the privately owned and voluntary organizations. Such was the case for SPH and SRHA.

At the time that the first affiliation agreement was developed in 1992, the Grey Nuns of Montreal owned SPH. SPH retained its own board, chief executive officer (CEO), and management structures. It is the oldest hospital in Saskatoon and is located in a large multicultural and Aboriginal neighbourhood. SPH has been serving Saskatoon and this poor, minority, and disadvantaged population since 1905. Saskatoon also has a large Catholic population, and there was a concern about the survival of Catholic Health Care in the region. These feelings were fuelled by the knowledge that in Regina, Saskatchewan, the Sisters of Charity had handed over ownership of their Catholic Hospital to the Regina Health Authority. The Grey Nuns of Montreal originally owned SPH, but as many nuns aged and moved back to the Mother House in Montreal, the Grey Nuns transferred ownership of SPH to the SCHC in 1999.

In the early 1990s Saskatchewan needed to look at other models for delivery of health care to curb spiralling health care costs. Regionalization was occurring simultaneously with other significant events in Saskatoon. Table 1 presents the dimensions of ownership, governance, and administration structure in SRHA and SPH before and after regionalization and the partnership agreement. The other two acute care hospitals were owned by the provincial government, and ownership was transferred to the SHRA with regionalization. After regionalization, the board governance structure for SPH continued to be volunteer, and the SCHC appoints members. Prior to regionalization, the RUH and the SCH had separate appointed boards, similar to SPH. With regionalization, one regional board was created for publicly funded healthcare organizations. The CEO reporting structure for SPH has not changed: The CEO is an employee of SPH and reports to the SPH board. Prior to regionalization each hospital had its own CEO, but since regionalization, SPH has one CEO, and the regional health authority has a CEO who reports to the regional board. Prior to regionalization, each hospital had a separate medical staff and chief of staff, human resources department, and senior administration for each hospital. These administrative functions were amalgamated, with the exception of the human resource function. SPH continues to have a partial, separate human resources department to deal with frontline staff and managers.

At the same time that regionalization was occurring, discussions were held around reducing the number of acute care hospitals in Saskatoon from three to two. With new technologies and the move to outpatient and ambulatory services, the two-hospital model had many advocates, and SPH was the logical choice for closure. If a two-hospital model was accepted, then the RUH, which was the teaching hospital, and SCH, which was newly built, were the obvious choices to remain open. The governing board of the SRHA decided to keep the three-hospital model because of the physical location of SPH and its relationship with its local and Catholic community. It then became a regional goal to maintain acute care service at SPH.

Table 1

Dimensions of the Integrated Partnership Agreement Between Saskatoon Regional Health Authority and St. Paul's Hospital Before and After Regionalization

Dimension	St. Paul's Hospital Pre-1994	St. Paul's Hospital 1995-2005	Saskatoon Regional Health Authority Pre-1994	Saskatoon Regional Health Authority 1995-2005
Ownership	SPH owned by the Grey Nuns of Montreal	SPH owned by the Grey Nuns of Montreal Ownership transferred to the SCHC in 1999	SCH and RUH Owned by the province of Saskatchewan	SCH and RUH Ownership transferred to the SRHA
Governance				
• Board	SPH Board appointed	SPH Board appointed	Separate Boards for RUH and SCH appointed	1995 SRHA Board composed of elected and appointed members by government
• CEO	Employed by SPH Board	Employed by SPH Board	Employed by RUH and SCH Board	Employed by SRHA Board
Administration				
• Medical staff	Separate Medical Staff and Chief of Staff for	One regional Medical Staff with one Chief of Staff	Separate Medical Staff and Chief of Staff for SCH and RUH	One regional Medical Staff with one Chief of Staff
• Senior admin	SPH VPs, SPH departments	VPs, SRHA employees, all departments integrated	Separated SCH and RUH VPs, and SCH and RUH departments	VPs SRHA employees all departments integrated
• HR	Own employees	SPH based managers and frontline staff SPH employees	SCH and RUH separate HR	SRHA HR for SCH and RUH

Note. SPH = St. Paul's Hospital; SRHA = Saskatoon Regional Health Authority; SCH = Saskatoon City Hospital; RUH = Royal University Hospital; SCHC = Saskatchewan Catholic Health Corporation; HR = Human Resources.

When the regional health board decided to continue to operate three acute care hospitals, the distribution of clinical services among the hospitals needed to be determined. With the introduction of new technology and standards of care and a move to more outpatient service delivery and day surgery, there was a real concern about maintaining a critical mass of staff with the education to provide excellent service. Second, there was a realization that it was not possible for all three hospitals to provide specialty services and that consolidation of services was the only way to survive. One of the mandates of the newly formed health authorities was to look at best practices for all health services and to amalgamate services wherever possible.

The first service to be integrated was women and children's health. Because SPH is a Catholic organization, some of the reproductive technologies or beginning-of-life decision making would contradict SPH Catholic health ethics (Wagner, 1998). Therefore, the decision was made to move all maternal and child services to SCH from SPH. SPH accepted that, to advance of fertility and reproduction services and technologies, a maternal child center of excellence had to be in a facility that could best benefit all residents of the community. Although SPH agreed with the closure of its maternity program, it perceived it as a huge loss after 90 years of delivering babies. Another major decision was to amalgamate all women and children's health services in one or two centers because there was not enough gynecological surgery to maintain a critical mass of expertise in each hospital, and services would be best consolidated at one or two sites.

As operational decisions were being made by the SRHA board, the provincial government (Saskatchewan Health) announced the first health board elections for the fall of 1995. The new regional board would now be composed of elected and appointed

2

members. However, as a voluntary organization, SPH would continue to select its own board members. The SPH board chair and CEO recognized that with the forthcoming changes to the SRHA board, the loss of maternity services, and the need to amalgamate other services, it was necessary to create a new relationship with the regional board.

At the same time that regionalization was occurring, the budget for delivering acute care services was reduced by 13% two years in a row (Wagner, 1998). This climate created distrust and power struggles between regional authorities and their affiliates. The affiliated organizations had to negotiate with the regional authorities for their piece of a shrinking pie. Because of the nature of affiliation agreements, power and control issues created tension, leaving the affiliated organizations feeling powerless and vulnerable. Planning for health services and budgeting processes produced highly charged, competitive, and potentially destructive environments.

It was in this turbulent and highly charged environment that the board and executive leaders of SRHA and SPH began discussions to create a partnership agreement. On April 18, 1996, both organizations signed a document entitled *St. Paul's Hospital-Saskatoon District Health Joint Service Management Partnership*. In the LINCS Research Program this partnership agreement was conceptualized as an administrative integration strategy. Interviews were conducted with board members, chief executive officers, and senior managers to gain an understanding of the contents of the partnership agreement and how it was operationalized. The guide for these semistructured interviews is presented in Appendix A. As a student research partner in the LINCS research program, the author of this thesis had the opportunity to conduct these interviews. This experience led to the development of the research questions that were explored in a secondary analysis of the interview data and reported in this thesis.

One of the senior leaders who participated in the interviews suggested the term *values-based leadership*. This individual believed that successful implementation of the partnership agreement has been possible because leaders in both organizations are committed to the shared values. These values were articulated in the guiding principles of the partnership agreement (SHRA & SPH, 2005b), which are presented in Appendix B. Both boards also adopted a supplementary document entitled *Decision Framework* (Shared Services Committee, 1996; summarized in Appendix B). The guiding principles and decision framework statements of shared values represent the policy decisions of the boards of SRHA and SPH. Senior executives in both organizations were charged with the responsibility of implementing the partnership agreement. In so doing, they reorganized the delivery of health services in Saskatoon and the administrative structure for the region and SPH. This study reported in this thesis explores the behaviours and characteristics of the leaders who designed and implemented the partnership agreement.

Significance of the Study

The partnership agreement between SPH and SRHA was a major change strategy that restructured the delivery of healthcare in the community. According to Wheatley (1997), more than two thirds of organizational change efforts fail, and interorganizational change initiatives are particularly complex. The leaders in Saskatoon developed an unprecedented collaboration strategy to address the crisis of budget deficits, an aging workforce, crumbling capital infrastructures, high public expectations, increasing technological and pharmaceutical advances, the aging population, rising costs of care, and concerns about patient safety in their health region. In this context it is significant that 10 years after the original agreement was signed, the partnership agreement between the two organizations was reaffirmed and continues to be the framework for current health care decisions. It is therefore of significant interest to explore and describe the leadership characteristics, behaviours, and leadership styles of past and present leaders in SRHA and SPH who designed, implemented, and sustained this change.

Terms and Abbreviations

The following definitions and abbreviations are used in this report:

1. **Leadership behaviour:** "Particular acts in which a leader engages in the course of directing and coordinating the work of his group members" (Bass & Stogdill, 1974, p. 14).
2. **Leadership characteristic:** A trait or quality expected in a leader (Kouzes & Posner, 2002, p. 24).
3. **Leadership styles:** "The different combinations of tasks and relationship behaviours used to influence people to accomplish goals" (Huber et al.., 2000, p. 254).
4. **Values-based leadership:** For the purposes of this study, values-based leadership is "broadly defined as leadership based on foundational moral principles of values such as integrity, empowerment, and social responsibility" (Reilly & Ehlinger, 2007, p. 245).
5. **LINCS:** Listen, Innovate, Navigate, Connect, and Share Research Program. This program of research was funded by the Canadian Health Services Research Foundation and the Alberta Heritage Foundation for Medical Research, with research partners in Alberta and Saskatchewan; it was carried out between 2003 and 2006.

6. **SRHA:** Saskatoon Regional Health Authority. From 1995 to 2005 the SRHA underwent three name changes. For the purposes of this study they will be referred to as SRHA. However, references to documents will contain the name at the time that the document was produced.
7. **SPH:** St. Paul's Hospital
8. **SCHC:** Saskatchewan Catholic Health Corporation
9. **CEO:** Chief Executive Officer

Overview of the Study

In this chapter the background, context, and significance of a study to examine values-based leadership in two healthcare organizations over a 19-year period has been described. Chapter two of this report contains a review of the literature that provided a scholarly context for the study and its methods. The methodology of the study is discussed in chapter three, and the findings are presented in chapter four. Leadership behaviours and characteristics of past and present leaders in Saskatoon are discussed and categorized thematically. In chapter five the findings are discussed in practical and theoretical terms. Conclusions, limitations, and recommendations for further research are presented in chapter six.

CHAPTER TWO:

LITERATURE REVIEW

In a recent review of the research literature on leadership in business and health care, Vance and Larson (2002, p. 169) concluded that studies of leadership are primarily descriptive. Only 4.4% were reports of research based on data or a comparison of outcomes. Imprecise definitions of leadership and a lack of sensitive and specific outcome-measurement tools have characterized leadership research. The small sample sizes and descriptive nature of most study designs prohibit generalizations (p. 170).

This review was conducted to identify references to values-based leadership in the published literature. The health care literature between 1995 and 2005 was searched using CINAHL, Pubmed, and PsycINFO and the following terms as search strategies: *values-based leadership*, *social values and leadership*, *ethical leadership*, *virtues-based leadership*, *servant leadership*, and *spiritual leadership*. The search was limited to the 10-year period which corresponds with the time period of interest in this study. When the search terms were applied to the literature, 52 articles were located.

Categorization of the Literature

The literature analyzed for this study can be divided into two broad categories, research reports and other literature. Of the 52 articles, a total of 26 were discarded because they did not explore values in the context of principles or standards or because they were newsletters, editorials, or published in non-peer reviewed literature. The nonresearch literature involved publications that presented theoretical frameworks, model development, literature reviews, and expert opinion. For the purposes of this discussion, expert-opinion literature is defined as literature that does not contain references to research. Articles were included in the review if the author has expert qualifications and the paper was published in peer-reviewed literature or book form.

The research studies were further categorized using Brink and Wood's (2001) typology for categorizing research into three levels (p. 70). In the typology, Brink and Wood defined a level 1 question as a study that is exploratory and/or descriptive. Data are collected using qualitative research methods for exploratory studies and qualitative and/or quantitative research methods for descriptive studies. Results are determined using content analysis and /or descriptive statistics. Usually there is limited research on the topic, and the design is used to describe what exists, with no inferences of relationships or cause and effect (pp. 70-71). Level 2 research questions focus on relationships between two or more variables to statistically describe those relationships. Methods are conceptual or designed for hypothesis testing. Conceptual or theory-based questions analyze the correlation or association of results, and hypothesis testing analyzes comparisons or differences between groups (pp. 72-73). Level 3 research questions determine the cause and effect between variables. The purpose of these studies is to test theories through direct manipulation of variables. Level 3 research questions determine why relationships exist between variables. However, some variables cannot ethically be manipulated and therefore are not amenable to developing level 3 research questions (pp. 75-76). Table 2 summarizes the number of articles found in each of the identified categories. Only eight research papers were found, and a majority of the papers were opinion based.

Table 2

Results of Literature Review

Category	Level 1 research	Level 2 research	Non - Research	Discarded (irrelevant)
Number of articles	4	4	18	26

Nonresearch Literature

The nonresearch literature, including literature reviews, theoretical frameworks and models, and expert opinion, presented in this section refers values-based leadership, which is "broadly defined as leadership based on foundational moral principles of values such as integrity, empowerment, and social responsibility" (Reilly & Ehlinger, 2007, p. 245). Table 3 summarizes literature reviews by Leatt and Porter (2003), Pendleton and King (2002), and Schwartz and Tumblin (2002); papers on theoretical frameworks or models by Bass and Steidlmeier (1999), Bruhn, (2004a, 2004b), Gosling and Mintzberg (2003), Gragnolati and Stupak (2002), Howatson-Jones (2004), Perra (2001), Shirey (2005), Strack and Fottler (2002), [2003 in ref list] Trofino (1995), and Vitello-Cicciu, (2002); and expert opinion by Bennis (1999), Kuczmarski and Kuczmarski (1995), O'Toole (1995), and Secretan (2004).

Schwartz and Tumblin (2002) completed a literature review on transformational, situational, and servant leadership (p. 1419). The three models support the concept of relational leaders who engender mission-, vision-, and values-centered organizations. A healthy organization has a mission that helps to define a strong sense of purpose. With this type of leadership, employees feel empowered and find meaning and purpose at work

Table 3

Literature Review, Theory Frameworks and Model Development, Expert Opinion

Category	Author	Model or theory	Findings
Theoretical framework	Bass & Steidlmeier, 1999	Authentic transformational leadership	Authentic transformational leadership grounded in moral foundations (moral character, ethical values and morality of the process)
Expert opinion	Bennis, 1999		The new leadership has to include followers in development of vision, goals and strategic planning.
Model development	Bruhn, 2004a	Organizational good model	The organizational good" is the soul of an organization; 4 components to the model. Leaders reinforce ethical principles by modeling them for an organization to thrive.
Theoretical framework	Bruhn, 2004b	Drucker's change leaders vs. change managers	Change leaders see change as positive and empower those in the organization to understand change and how it aligns with personal goals and values.
Theoretical framework	Gragnolati & Stupak, 2002	Kouzes & Posner	High performing hospitals and law courts develop concepts, and policies based on positive values (empowerment, participation, involvement and spirituality).
Model development	Gosling & Mintzberg, 2003	Management model	Managing involves five tasks, managing the self, managing organizations, managing context, managing relationships, and managing change.
Theoretical framework	Howatson-Jones, 2004	Servant leadership	Description of servant leadership. Comparison between different leadership types.
Expert opinion, published book	Kuczmarski & Kuczmarski, 1995		Discusses disillusionment, isolation and hopeless in work place and how leaders can re-energize employees with commitment for the organizations.
Literature review	Leatt & Porter, 2003		Description of the changing concepts of leadership concepts in business and healthcare.
Expert opinion, published book	O'Toole, 1995		Leadership is based on values. Values-based leaders provide conditions to empower followers to perform effectively towards a common goal.
Literature review	Pendleton & King, 2002		Discussion of leadership styles and the value of these to the medical administrators.

(table continues)

Category	Author	Model or theory	Findings
Theoretical framework	Perra, 2001	Integrated leadership practice model	Theory identifies nine qualities of successful leaders, self knowledge, respect, trust, integrity, shared vision, learning, participation, communication and change facilitator
Literature review	Schwartz & Tumblin, 2002	Transformational, situational and servant leadership	A review of 12 articles on leadership philosophies and attributes
Expert opinion, published book	Secretan, 2004	Destiny-cause-calling theme	Inspirational leadership, book about inspiring others and ourselves by helping to find meanings and passion for work
Theoretical framework	Shirey 2005	Ethical principles	Nursing leaders role in developing an ethical nursing practice climate based on ethical principles. Comments on measurements and strategies for creating an ethical environment.
Theoretical framework	Strack & Fottler, 2003	Kouzes' and Posner's Leadership Practice Inventory (LPI) and Wilbur's four quadrant model of spiritual reality	Review of the literature for links between effective leadership and spirituality.
Theoretical framework	Trofino	Transformational leadership	Globalization, empowerment and technology impact of future trends. Nursing need to develop transformational leaders to address these future trends.
Theoretical framework	Vitello-Cicciu, 2002	Emotional intelligence	Defines emotional intelligence (EI) and compares the theoretical concepts of Mayer and Salvoy, and Goleman.

(p. 1420). Schwartz and Tumblin described Greenleaf's concept of servant leaders, who (a) are focused on their employees; (b) believe in the inherent worth of each individual; (c) are active listeners who display empathy for everyone; (d) role-model behaviour; (e) have a healing influence on people, the organization, and the community; (f) recognize that change begins with themselves; (g) practice reflection and introspection; and (h) take care of their followers' needs first and empower them to meet the needs of others (p. 1421). A "servant leader" is one who acknowledges indebtedness to followers. Servant leaders positively affect the culture or soul of the organization, by being role models of servitude. The integrity of the organization depends on the integrity of the leaders, and ethical behaviour is the foundation for integrity (p. 1421).

Pendleton and King (2002) reviewed the literature on values and leadership. Values, when used appropriately, are guiding principles that leaders and the organization use. When decisions and actions reflect these values, followers develop trust. Research studies have demonstrated that organizations with clear vision and values outperform other comparable organizations whose vision and values are not clear. Pendleton and King stated that researchers have found that an organization with long-term profitability and survival has a strong orientation to values and has developed a culture that supports the values. Again, there is a link between the organization's vision and values, and both provide guidance in actions that support the organization's purpose and meaning. Values become the foundation for trust, respect, inspiration, innovation, and commitment. Great leaders help followers to understand the values and vision and continually reexamine actions and decisions in light of the organization's values. Followers can comprehend and support tough choices as long as they can link them to the organization's values.

The key attributes of transformational leaders are the ability to communicate the vision, consideration, concern for employees, and the ability to fulfil commitments. Transformational leaders consider each individual employee's needs, strengths, and education requirements and try to energize and/or intellectually stimulate them (Schwartz & Tumblin, 2002, p. 1424). Schwartz and Tumble outlined the work of Goleman, who identified effective leaders as having high EI based on the concepts of self-awareness, self-regulation, motivation, empathy, and social skills (p. 1424). According to Schwartz and Tumblin, Druskat and Wolff talked about emotionally intelligent productive teams that were founded on mutual trust, effective participation, cooperation and collaboration, and a sense of group identity (p. 1424).

Schwartz and Tumblin (2002) stated that Huey suggested that postheroic leadership models embody core values, which supports the idea of relinquishing control for the empowerment of the entire organization (p. 1425). The idea is that decisions can be made quickly and at the most appropriate level. However, most executives find it difficult to give up command and control (p. 1436).

Strack and Fottler (2002) discussed two theoretical models to determine a relationship between leadership and spirituality. First, they reviewed the literature to ascertain whether there is a connection between great leaders and spirituality. They concluded that the complexity of the spirituality and leadership constructs make it impossible to draw clear links between the two. However, they suggested that outstanding leaders are grounded in a spiritual dimension, which, in turn, results in the ability to inspire, create a shared vision, role-model, and encourage and enable others. Strack and Fottler outlined a model developed by Wilbur that describes four dimensions of spirituality: (a) the subjective dimension, which incorporates the individual's expressed spirituality; (b) the individual external dimension, which includes the individual's actions and behaviours; (c) the internal group dimension, which is the effects of beliefs and values on society; and (d) the external group dimension, which is the spirituality developed in the work environment (p. 5). They also explored Kouzes and Posner's Leadership Practice Inventory (LPI) model of leadership effectiveness that they developed from in-depth interviews (p. 8). The five leadership practices that they identified are challenging the process, sharing a vision and inspiration, enabling, modeling, and encouraging—all of them centered on others (p. 8). Strack and Fottler tried to demonstrate conceptual links between the two models by overlaying Kouzes and Posner's model on Wilbur's four-quadrant model. "Encouraging the Heart" fell into Wilbur's quadrant 1, the internal individual; "Model the Way" fell into quadrant 2, external individual; "Inspiring a Shared Vision" fell into quadrant 3, internal group; and "Enable Others to Act" and "Challenge the Process" fell into quadrant 4, external group (p. 13). They suggested that these findings show a strong link between leadership and spirituality (p. 16).

Leatt and Porter (2003) presented a brief summary of emerging theories and concepts in leadership that they labelled "landmark" (p. 19). They described Burns's (1978) transactional and transformational leadership theory and emphasized transformational leadership, which they described as a social construct, with the key being a respectful and supportive relationship between the leader and follower. Leatt and Porter discussed transformational leadership in the context of Ginter, Swayne, and Duncan's (2002) report on the role of leader as strategist and the importance of inspiration in pursuit of a vision with a focus on the future. Leatt and Porter then concluded that strategic leaders develop trust, empower followers, and encourage innovation (p. 17).

The next concept that Leatt and Porter (2003) presented was Goleman's (2000) *emotional intelligence* (EI), which, they argued, distinguishes great leaders from the average (p. 17). The EI framework is based on emotional competency, which is both personal and social. These competencies are not described in this paper. Leatt and Porter suggested that EI leaders are able to change leadership styles based on the situation (p. 18).

Leatt and Porter (2003) also reported on research by Buckingham and Coffman (1999) that suggested a direct relationship between organizational performance and employee satisfaction. Leatt and Porter stated that the relationship with an immediate supervisor is the best predictor of employee satisfaction (p. 18). Leatt and Porter surmised that this affirms the need for the leader to create an environment that supports and nurtures middle managers (p. 18), who, in turn, support and nurture their followers. Work by Collins (2001) on level 5 leaders is the last theory or concept presented. Leatt and Porter proposed that Collins's concept of personal humility challenges the theories on charismatic leadership (p. 19).

Leatt and Porter (2003) described the lack of many formal leadership education programs in business and especially in healthcare (p. 20). They suggested that, with the major changes and turbulent healthcare environment, there is a need for qualified leaders and that "to lead at times of major reform requires different skills, knowledge, attitudes and competencies than at times of predictable and stable circumstances" (p. 23). Healthcare leaders have to focus on the organization's values, act ethically and with integrity, be able to adapt to continuous change. As well, they have to be aware of the needs of the community and be committed to patient-centered care (p. 26). Given the competencies that leaders require, Leatt and Porter proposed an education model that consists of principles to guide the development of leadership in healthcare (p. 27): lifelong learning, graduate and continuing education, competency-based programs with entrance requirements, frameworks of leadership development and quality improvement, understanding of interdisciplinary teams and group process, and focus on organization advancement (p. 29).

Bruhn (2004a) stated that ethically responsible organizations have clear values that result in honest and respectful environments and principles that outline standards of excellence and quality improvement. Bruhn presented a conceptual model that is referred to as "the organizational good" (p. 4). This model consists of four components: (a) Leaders are people with character, (b) the values of the organization are clear, (c) the leaders model behaviour consistent with the values, and (d) all leaders and follower are "behaviourally accountable" (p. 6). According to Bruhn, these components help to create an ethically sound organization. It is important that leaders model behaviour that is ethical and in congruence with the organization's values and is discussed throughout the organization. Bruhn described an ethical environment as "one of openness, respect, and dialogue" (p. 7). Ethical leaders do the right thing, are honest and fair, and, because of these attributes, create a positive work environment. Exemplary leaders ensure that the organization's values are embedded in the culture of the organization and that its core values endure long after they have left (p. 9).

Shirey (2005) used a theoretical framework of ethical principles to discuss the responsibility of nursing leaders to ensure an ethical climate in nursing practice. She identified the organization's mission, vision, and values as key to this process. Values must be clearly articulated, and there must be consistency between the stated values and the leaders' actions and behaviours (p. 60). According to Shirey, "Values encompass moral standards and represent the core principles that guide organizational behavior"

(p. 60). The organization's mission, vision, and values are guiding principles during times of change and uncertainty, and Shirey charged that it is the role of the nursing leader to ensure that the mission, vision, and values are a part of everyday decision making and actions. An ethical organization acts with integrity and in congruence with its mission, vision, and values.

According to Shirey (2005), because healthcare organizations have caring missions, an ethical nursing leader ensures that this translates into a caring work environment (p. 60). She discussed this concept in the context of six ethical principles. The first principle of autonomy encompasses respect for and valuing of nurses. An environment that encourages self-determination and autonomy empowers nurses. Shirey addressed the principles of beneficence and nonmaleficence together and explained that they refer to the provision of safe, quality patient care. The leader's role is to ensure that the environment is safe by addressing issues such as adequate staffing and continuing education (p. 61). Shirey discussed the fourth principle of distributive justice in the context of a fair and equitable environment. Veracity is the fifth principle and is referred to as *truth-telling*, which includes clear, open, and honest communication. The sixth principle is fidelity, which Shirey described as the honouring of commitments and obligations. It also includes concern for the individual. The measure of an organization's ethical climate should be a starting point for developing strategies to create an ethical climate. Shirey concluded that organizations that live and practice their values create ethical environments that increase nurses' morale, job satisfaction, and commitment to the organization (p. 65).

O'Toole (1995) published a book on the effects of values-based leadership on leading change in which he suggested that leadership "is not about style but about ideas" (p. x). These ideas are values that motivate and energize people. O'Toole recommended that leaders engage followers and always be mindful of the followers' goals and values. He acknowledged that, although it is important to listen to the desires of the followers, the leader has to be able to transcend the superficial, discern the underlying true needs, and be able to articulate them (p. 10). A leader creates a vision that becomes the followers' vision because it addresses the followers' needs and values. Vision, values, trust, authenticity, and integrity are all required to lead a complex, dynamic, and changing organization. According to O'Toole, leaders must always use the underlying values to inspire followers and, by doing so, empower followers to lead the change: "Values-based leadership is an attitude about people, philosophy and process" (p. 14). He described these values-based leaders as courageous, authentic, passionate, and persistent and as acting with vision, conviction, and integrity (p. 21). As did other authors, O'Toole agreed that trust is the cornerstone of leadership and is predicated on integrity and a willingness to serve (p. 27). Values-based leadership involves aligning everyone's values and goals, which O'Toole acknowledged is difficult. He concluded, "Values-based leadership brings order to the whole by creating transcendent values that provide a tent large enough to hold all the different aspirations" (p. 258).

In another paper, Bruhn (2004b) discussed the difference between change leaders and change managers based on Drucker's (1999) framework on the characteristics of leaders involved in change. Change managers tend to view followers as problems, whereas change leaders view them as the biggest asset. Change leaders realize that change has to be tied to the organization's values and understand the importance of aligning individual values with those of the organization (p. 133). They also understand the need to maintain the organization's vision, mission, and values and use them to guide change. In contrast, change managers do not understand the importance of tying the organization's vision, mission, and values to the change initiative. They do not attempt to help individuals to align their values with the change, which leads to insecurity and resistance to change. Leaders in day-to-day operations use open, honest communication to develop trust. Similarly with change initiatives leaders must share plans openly and honestly with followers. According to Bruhn, leaders plan change but allow others to implement change. The leader's role is to oversee the change and focus on fairness and integrity (p. 135). Mangers, by contrast, focus on the implementation and lose sight of the bigger goals. Leaders are aware of the life cycle of the organization and use this knowledge to plan change strategies. Unlike managers, leaders keep the vision in sight but are open to adapting plans and are comfortable with ambiguity. Bruhn suggested that boards should be "recruiting leaders who have values-based visions" (p. 135). These leaders use open, honest communication, understand the importance of values, and establish partnerships to assist with change initiatives. Change leaders help followers to see 'what's in it for them.' Leaders engage the entire organization in gaining an understanding of the goals for the change, and they encourage followers to plan how the change will be implemented in their area (p. 139). Leaders are successful in increasing morale, productivity, and staff retention by involving followers in change (p. 140).

Gosling and Mintzberg (2003) stated, "Most of us have become so enamored with 'leadership' that 'management' has been pushed into the background" (p. 54). Although leadership is important, leadership without management promotes a disconnect between the leader and the day-to-day operational requirements. Gosling and Mintzberg created a five-module framework, which they referred to as “mind-sets” (p. 56) for management education: (a) reflective: the ability to manage self through reflection and understanding the meaning of experiences; reflective managers understand the importance of history, both the organization’s and their own; (b) analytical: the ability to analyze situations by using data and outcome measures in the context of relationships and personal and organization values (p. 58); (c) worldly: the ability to manage and understand the complex context that includes the internal environment—the organization’s mission, vision, and values—which defines the culture, as well as the external environment, which is local and international; (d) collaborative: the ability to build relationships; the organization must focus on the internal environment first by listening, being visible, and being involved; and collaborative managers “establish the structures, conditions, and attitudes through which things get done” (p. 60); and (e) action: the ability to realize what needs to be maintained and what needs to be changed. Change is strategized and planned. However, Gosling and Mintzberg cautioned that change is complex and requires skills from the reflective, action, and collaborative mind-sets. Although they are presented as individual modules, the mind-sets overlap. According to Gosling and Mintzberg, “Effective performance means weaving each mind-set over and under the others to create a fine sturdy cloth” (p. 63).

Perra (2001) proposed the integrated leadership practice model (ILPM) in an article on theory development. The theory identifies nine attributes of a strong leader: “self knowledge, respect, trust, integrity, shared vision, learning, participation, communication, and change facilitator" (p. 69). The first four are the fundamental principles of the model; the remaining attributes build on the first four. The first principle, self-knowledge or self-awareness, is an introspective practice that helps the leader to identify his/her values and beliefs and to understand how they influence his/her behaviour and decisions (p. 70). Respect for self and others is the second principle of the ILPM. Relationships are key to this model and need to be founded on respect, honesty, and trust (p. 70). Leaders who act in congruence with their values build trust. Integrity is the application of trust and honesty at all relationship levels, individual, organizational, and community (p. 70).

Staff need to understand the values and vision of the organization to find meaning and purpose in work (Perra, 2001, p. 70). The third principle of the ILPM emphasizes the need for continuing education and professional development for everyone in the organization (p. 71). Along with professional development and personal growth, the leader also needs to support spiritual renewal. Individual spirituality and an understanding of the organization's values and vision give meaning and purpose to staff. It is important that leaders be able to articulate the organization's vision and values for others so that they comprehend how it fits with their own values (p. 72).

The fourth principle is communication, which is the foundation for the development of trusting and respectful relationships. Active listening skills, information sharing, and feedback will help to develop staff; and communication skills will help to articulate personal and organizational values (p. 72). These values need to be clear, and board members, executives, and staff need to put them into action on a daily basis. Employees who are spiritually aware and find meaning and purpose at work will be empowered to make decisions and participate in problem solving for the greater good of the organization (p. 73).

Howatson-Jones (2004) described different transformational attributes such as respect, influence, creativity, and support that create harmony (p. 22). She explored the concept of servant leadership in the health care setting, which she stated is based very much on mutual trust and empowerment of followers and is well suited to building teams and relationships to move groups forward in organizations. Power is used ethically to encourage teamwork and collaboration "in an atmosphere of mutual respect and trust" (p. 23). Howatson-Jones suggested that servant leadership is based on trust and interdependence and that this type of leadership requires a leader who is self-aware and empathetic and acts authentically and with integrity. These attributes are required to understand followers' different worldviews, which is important to ensure that the followers' desires and goals are realized in the context of the organization's goals and values (p. 23).

Vitello-Cicciu (2002) explored the concept of EI and compared Mayer and Salovey's (1997) framework with Goleman's (1998). Mayer and Salovey developed a conceptual framework of a model with four abilities: "perception appraisal and expression of emotions, emotional facilitation of thinking, understanding and analyzing emotions, and regulation of emotions to promote emotional and intellectual growth" (p. 204). They perceived these abilities as hierarchical; each stage is mastered before moving to the next.

Goleman's (1998; as cited in Vitello-Cicciu, 2002) mixed model of EI has five concepts: self-awareness, self-regulation, motivation, empathy, and social skills (p. 205).

Under these broad categories, he identified 25 competencies of EI leaders. According to Vitello-Cicciu, the competencies are hierarchical and include the following:

> emotional awareness, accurate self assessment, self-confidence, self-control, trustworthiness, conscientiousness, adaptability, innovation, achievement drive, commitment, initiative, optimism, understanding others, developing others, service orientation, leveraging, diversity, political awareness, influence, communication, conflict management, leadership, change catalyst, building bonds, collaboration and cooperation, and team capabilities. (p. 205)

Although the general public has embraced EI, scholars have criticized the EI model because little research has validated the assumptions. Vitello-Cicciu (2002) stated that a great deal of work needs to be done in the area of EI measurement and the significance of EI to leaders. However, she discussed the importance of EI to nursing leaders. Nursing is a relational profession, and successful practitioners require EI to identify, analyze, and manage their own emotions and the emotions of others.

Trofino (1995) identified the need to develop nursing leaders who can address the future trends of globalization, complex change environments that require empowered staff, and technology (p. 42). She stressed that globalization means that organizations must focus on serving the needs of the community. She described empowerment as decentralized decision making, which encourages creativity and collaboration, and advised that technology be accepted and implemented to revolutionize how care is delivered (p. 42). Trofino discussed multiskilled workers, advance practice nurses, case management, health-information specialists, and increased family and patient involvement as some of the major trends that will impact nursing (pp. 43-44). Nurses will be an integral part of these trends and, according to Trofino, need to be prepared to lead these changes. She suggested that nursing requires transformational leaders and that leaders need to clearly articulate vision and goals and help followers align with the vision and goals to create an environment in which leaders and followers "transcend their own self-interest to reach higher goals" (p. 45). Trofino referred to the work of Senge (1990) in her discussion of leaders as designers who articulate vision and values and model behaviours that reinforce the vision and values, teachers who assist followers in aligning their values and goals with those of the organization, and stewards who are focused on serving others (p. 45). She asserted that mentoring, coaching, teamwork, recognition, empowerment, persuasion, collaboration, creativity, and intuition are all required leadership traits to cope with future trends (p. 46).

Bennis (1999) suggested that essential to leadership is a process of involving people, gaining their commitment, and energizing them to participate in the tasks related to achieving mutual goals. Leadership is about relationships with followers and influencing the process by which they jointly achieve organizational goals. Bennis stated that leaders focus followers on "what is important" (p. 77), and this is accomplished through a clear and powerful vision. Bennis describes trust as one of the most powerful concepts in leadership. Leaders develop trust by acting competently and consistently with fairness, caring, and authenticity (p. 78). Leadership occurs between people and is a reciprocal process. The followers determine whether the leader is effective or not. Great leaders know that leadership is a social construct founded on respect and dignity. Bennis summarized: "Exemplary leadership and organizational change are impossible without the full inclusion, initiatives and cooperation of followers" (p. 74).

Bass and Steidlmeier (1999) addressed the ethics of transformational leadership and claimed that ethical leadership is based on three principles: the leader's character, the organization's and leader's values, and the follower's ability to make ethical choices

(p. 182). Bass and Steidlmeier argued that authentic transformation leadership is grounded in moral values that suggest moral intention and moral consequence (p. 183). They examined the "issues of transcendence, agency, trust, striving for congruence in values, cooperative action, power, persuasion, and corporate governance to establish the strategic and moral foundation for authentic transformational leadership" (p. 181). Authentic transformational leaders (ATLs) value relationships and look to serve others. They have clearly stated values and high ethical standards. ATLs care and are concerned about followers and engage them in the process of developing a shared vision and goals while encouraging questioning and creativity (p. 189). ATLs look beyond themselves with a focus on doing what is right for the organization and the community. Authentic transformational leadership "is the type of leadership grounded in values, based in trust, and rooted in spirituality" (p. 191). ATLs are concerned with justice, fairness, and honesty. The biggest criticism of transformational leadership is value congruence. Critics argue that it is unethical to encourage followers to go beyond their self-interests for the sake of the organization (p. 201). Bass and Steidlmeier's response is that with values-based leadership, leaders and followers share vision, values, and goals and that congruence increases competency and job satisfaction. ATLs use vision and values to set the groundwork for a common understanding of purpose and goals. "Rather than being unethical, true transformational leaders identify core values and the unifying purpose of the organization and its members, liberate their human potential, and foster pluralistic leadership and effective, satisfied followers" (p. 211).

According to Gragnolati and Stupak (2002), leaders in healthcare have to be able to clearly articulate organizational values to staff. They stressed the need to be interdependent and humble and to share power and decision making to move organizations forward in turbulent environments. They used Kouzes and Posner's (1995) leadership research to describe the attribute of leaders: Leaders "need to be optimistic, enthusiastic, energetic and positive about their organization's future" (p. 80). A leader must be able to communicate a vision and values to help inspire staff. Gragnolati and Stupak suggested a correlation between employee satisfaction and outcomes. Employees who can make a link between their work and the organization's mission will find their work more fulfilling and meaningful (p. 81). Finally, they outlined three strategic factors that lead to improved performance and outcomes: (a) focusing on the relationship with followers, listening to their needs and desires, and helping them to understand how they align with the organization's mission, vision, and values: (b) acting with integrity—their actions need to match their words; and (c) focusing on serving the community and the needs of the community to drive "the enterprise" (p. 85). They concluded that values and culture are anchors for the followers, the leaders, and the organization (p. 86).

Secretan (2004) published a book on inspired leaders whom he called *higher-ground* leaders, whom he suggested have three important attributes: (a) self-awareness: They are aware of the purpose and meaning of their life; (b) a cause: They know what they are doing and how it fits with their life purpose; and (c) a calling: They know how to use their gifts and talents to further their cause (p. 51). Secretan stated that these higher-ground leaders develop serving relationships with others (p. 141) that are genuine and come from a place of abundance and love, which results in a connection that leads to inspiration. Secretan spoke about the importance of values and cautioned that "values systems must always enhance the well-being of others and the planet" (p. 3). However, contrary to other literature on values-based leadership, Secretan believed that the development of a mission and vision and their use in strategic planning is an old model of leadership that manipulates, controls, and exploits followers (p. 20). He contended that, rather than focusing on the mission and vision, leaders need to focus on helping followers to identify their own destiny, cause, and calling and then on determining how they align with the values of the organization. Secretan described higher-ground leaders as courageous, authentic, truthful, loving, serving, and effective (p. 168), which leads to a consciousness in actions and behaviours. He defined this consciousness as *spiritual quotient* and suggested that it is the most important ingredient to inspire followers. Inspired followers lead to extraordinary organizational effectiveness (p. 177).

Kuczmarski and Kuczmarski (1995) talked about *anomie*, which they defined as the dissatisfaction of employees within organizations. This results in lack of motivation and poor performance, and they suggested that the reason for anomie is a lack of values and norms. They described values-based leadership as a "technique to solve the problem of anomie" (p. vi). Kuczmarski and Kuczmarski conducted 200 interviews with employees and identified 10 methods of improving job satisfaction:

> leaders who set the example, visibly practiced norms and values, greater responsibility, lower turnover, more direct, yet constructive confrontation, personal values linked to job, increased motivation and trust, values training and discussion, recognition and fairness, and pluralism and diversity demonstrated. (p. 68)

Based on these findings, Kuczmarski and Kuczmarski concluded that there is a need to develop norms and values to increase job satisfaction and described a process for organizations to build a foundation of norms and values that is built on relationships and employee engagement. Leaders recognize that employees' personal goals need to be linked with the organization culture. The attributes of these leaders include sharing decision making and responsibility, communicating effectively, encouraging learning, fostering diversity and creativity, and allowing conflict to occur in a respectful environment. Kuczmarski and Kuczmarski explained that core values influence decisions and strategic planning and that values create commitment and promote risk taking, which positively impacts organizational performance (p. 283).

Research Studies

Within the Brink and Wood (1991) typology, the studies by Collins (2001), McEnroe (1995), Tourangeau and McGilton (2004), and Valentino (2004) can be categorized as level 1 research and the studies by Cummings, Hayduk, and Estabrooks (2005), Dunham-Taylor (2000), McNeese-Smith and Crook (2003), and Upenieks (2003) as level 2 research. No level 3 research studies were found using the search strategies. The research questions, methods, and results related to values-based leadership will now be discussed in more detail. The research studies are summarized in Table 4.

Level 1 Research Studies

Valentino (2004) conducted interviews with middle managers of an organization that had merged (p. 393). She developed a conceptual model for organizations that are merging and reported the results of the interview using this model as a framework (p. 399). Valentino combined the competencies of Bennis's leadership framework with Schein's process for organization culture integration (p. 394). According to Valentino, both Bennis and Schein concurred that a clearly articulated mission and vision are important for an organization (p. 395). The vision must be based on stated values, and all decisions and actions need to reflect the vision and values. The mission must be tangible

Table 4

Literature Review Typology

Category	Author	Framework	Findings
Level 1	Collins, 2001	Transformational leadership	Leadership characteristic of 11 leaders whose companies went from good to great examples defined by sustained over a 15 year period
Level 1	McEnroe, 1995	Transformational leadership	Summary of findings of a Hay Group study of Catholic Leaders, identified 18 competencies.
Level 1	Tourangeau & McGilton, 2004	Kouzes & Posner: LPI	Psychometric testing of LPI revealed 3 factors: cognitive leadership activities, behavioural leadership activities, and supportive leadership activities.
Level 1	Valentino, 2004	Bennis: Four competencies of leadership Schein: Eight steps for cultural change	Development of an integrated framework for the transmission and integration of organization culture. Reports of interview of middle managers in a newly merged organization using framework
Level 2	Cummings, Hayduk & Estabrooks, 2005	Emotional intelligence (Goleman)	Resonant leadership style mitigated the negative effects of hospital restructuring
Level 2	Dunham-Taylor, 2000	Transformational and transactional leadership	396 nurse executives and 1,115 staff describe leadership characteristics and styles. Nursing satisfaction correlates to transformational style of executives.
Level 2	McNeese-Smith & Crook, 2003	Work values inventory	Highest rated value of supervisor relations which positively effected organizational commitment
Level 2	Upenieks, 2003		Magnet leaders empowering and people orientated.

and outline the purpose of the organization with clear goals and outcome measures. Communication is the key to helping people understand the organization's mission, vision, and values; and this begins with senior executives (p. 395). Trust and integrity are developed though management's consistently acting and making choices that reflect the organization's values and vision. Even difficult actions, or those with which some disagree, are supportable if there is confidence that the leaders are acting in accordance with the organization's values and vision (p. 397). The results of the interview suggest that in times of change and/or mergers, it is important that senior executives facilitate culture integration through focused discussions and activities that outline the organization's values and cultural assumptions. Even in times of stability, the organization's culture needs to be demonstrated, celebrated, and communicated regularly (p. 403).

McEnroe's (1995) selected his research study sample by requesting nominations of outstanding Catholic healthcare leaders from a group of 1,200 senior executives (p. 7). These outstanding leaders and their direct reports were given questionnaires and interviews to determine the leader's motives, managerial styles, and values. The research was aimed at describing the skills of these outstanding leaders. What were common among them were "reflection and introspection, as well as a sense of purposeful action" (p. 6). These executives reflected on what was happening in their organization and interpreted this within their own faith and values and the organization's values, and they demonstrated positive relationships focused on cooperation, collaboration, and a desire to serve others. The most significant finding from these outstanding leaders was the strong core of spirituality that consisted of faith in God and finding meaning. Their spirituality was directly related to behaviours seen in their service to the poor, the integration of values, firmness and compassion in their interactions, and their desire to develop programs to meet the needs of those they served (p. 8). Although McEnroe studied Catholic leaders, he did not imply that these values would not be present in other leaders.

Collins (2001) conducted quantitative and qualitative analyses of 11 companies to determine the characteristics that increased their performance from good to great and helped them to sustain it for 15 years or more (p. 69). The sample began with 1,435 companies that Fortune 500 had identified between 1965 and 1995. The companies from this list had to meet the following criterion to be included in the study population: They had to have cumulative stock returns at or below the general stock market for 15 years and then turned around to have stock returns at least three times the market over the next 15 years based on security prices, adjusted stock splits, and dividends (p. 69). From this initial criterion, Collins selected 11 companies.

Collins (2001) then conducted extensive research on these 11 companies. The qualitative analysis consisted of interviews with key executives and a review of the company's internal strategy documents, market analysts' reports, and articles written about the company. The quantitative analysis consisted of financial measures that included compensation packages, human resource indicators such as turnover and layoffs, and business strategies such as acquisitions and stock diversity (p. 69). To identify the characteristics that were present only in the good to great companies, Collins compared the findings to a group of control companies.

Although leadership styles were never the focus of the study, one key finding in all of the 11 companies was the attributes of the leaders. Collins (2001) labelled these leaders level 5 leaders, who are individuals who blend "extreme personal humility with intense professional will" (p. 68). According to Collins, these are mutually exclusive because leaders can have 'intense professional will' but lack humility. He gave an example of the famous corporate leader Lea Iacocca, who "courted personal celebrity" (p. 72) and focused on his role in transforming Chrysler. In contrast, level 5 leaders focus on people first and strategy second, and their actions and choices are based in faith and fact. They believe that the organization is the focus, not themselves. Their ambition is for the organization, and they spend time and energy on succession planning. They often pick and groom leaders who have stronger talents than they do themselves, which thus ensures the company's continued success (p. 75). These leaders rely on principles and standards to guide actions and decisions and demonstrate determination in doing the right thing and what is best for the long-term benefit of the company.

Tourangeau and McGilton (2004) stated that leadership behaviours such as articulating the organization's vision and values and encouraging and mentoring staff have been correlated with positive organization outcomes (p. 183). However, studies that measure these behaviours and outcomes need to be done in the healthcare environment (p. 184). Tourangeau and McGilton investigated the psychometric properties of Kouzes and Posner's LPI applied to nursing leadership (p. 182), which other researchers have used as a tool to measure the leadership behaviours of nursing leaders (p. 184). Sixty-seven nurse leaders who participated in a leadership program were given three questionnaires: "the LPI-self, the Maslach Burnout Inventory (MBI), and the Organizational Environmental Assessment (OEA)" (p. 187). Analysis of the questionnaires provided construct validity and reliability for a revised three-factor model compared to Kouzes and Posner's five-factor LPI. The three factors include cognitive leadership activities, behavioural leadership activities, and supportive leadership activities. Although more testing is required, this model may be useful in measuring nursing leadership.

Level 2 Research Studies

Cummings et al.. (2005) explored the connection between emotionally intelligent leaders and the impact of hospital restructuring on nurses (p. 4). They designed and tested a theoretical model using the results of 6,526 nurses who were practicing in acute care hospitals in Alberta and who had participated in the International Survey of Hospital Staffing and Organization of Patient Outcomes (p. 3). The survey reported on the emotional and physical well-being of the nurses and their work-environment characteristics. The model identifies causal relationships between hospital restructuring and effects on nurses, and the causal relationship that Cummings et al.. focused on was the EI of the nursing leader and the impact on the nurses (p. 9).

Cummings et al.. (2005) outlined Goleman's work on EI and described four domains of EI: self-awareness, self-management, social awareness, and relationship management (p. 95). Central to Goleman's theory is the ability to recognize and manage one's own emotions and those of others (p. 96). Cummings et al.. used Goleman, Boyatzis, and McKee's definition of highly emotionally intelligent leaders as resonant leaders, who are skilled communicators who use active listening, empathy, and support to inspire and create a vision for the future during a turbulent time (p. 3). Resonant leaders share information, are transparent, act with integrity, help people to focus on the meaning and purpose of their work, attempt to provide stable work environments and help to mitigate the negative impact of hospital restructuring on the nurses (p. 9).

To determine the impact of leadership skills on the organization, Dunham-Taylor (2000, p. 241) conducted a study of 396 nurse executives whom they randomly selected from across the US. Dunham-Taylor asked these executives to describe their leadership characteristics, personal power level, and work environment and three staff members who reported directly to these leaders to describe their boss's leadership style. Finally, she asked each leader's supervisor to rate the individual's effectiveness (p. 243).

The findings of Dunham-Taylor (2000) suggest that leaders who are more likely to mentor and empower others are more transformational (p. 249). The higher the leader's transformational score, the higher the staff's satisfaction and the work group's effectiveness, and the more participative the organization (p. 246). The transformational leaders were described as humble and as acting with integrity and intuition (p. 248). A transformational leader identifies and communicates the organization's vision and values: "Culture affects leadership as much as leadership affects culture" (p. 245).

McNeese-Smith and Crook (2003) conducted a research survey of 412 nurses to determine the relationship between values, age, generations, and job stages (p. 260). They randomly selected their sample of nurses from three not-for-profit hospitals in Los Angeles County (p. 261) and asked the nurses questions to determine their job satisfaction, their productivity, and the organization's commitment. The findings from this study suggest that clear values and directed priorities impact employee loyalty and commitment. Lack of congruence between the individual's and the organization's values negatively influence job satisfaction and turnover (p. 268). McNeese-Smith and Crook also found a correlation between the relationships with leaders, high staff satisfaction, and organizational commitment (p. 266). The researchers described leader attributes such as empathy and support for each individual as important. The transformational and servant leadership literature has identified similar attributes (p. 261).

Upenieks (2003) conducted interviews with 16 nurse leaders, 7 from magnet hospitals and 9 from nonmagnet hospitals (p. 457). Magnet hospitals are hospitals that meet certain criteria to be "certified by the American Nurses Credential Center for their excellence in nursing practice" (p. 456). The leaders from magnet hospitals identified the leadership attributes of "honesty; credibility; supportiveness; and visibility; having a passion for nursing; working collaboratively with others; flexibility" (p. 463) as important. These leaders also stated that their organization was values driven and supported nursing (p. 464). Nurses in magnet hospitals feel empowered and thus accountable and responsible for the care they deliver. Upenieks suggested that this positively contributes to collaborative working relationships built on trust and open communication (p. 467).

The literature was examined in its entirety and revealed support for the concept of values-based leadership. Four major themes were identified from the research and nonresearch literature: vision, values, and mission; ethics and integrity; service and inspiration; and legacy.

Vision, Values, and Mission

The first theme identified from the literature was vision, values, and mission. The organization's vision, values, and mission and the norms and standards form the culture or soul of the organization (Gragnolati & Stupak, 2002, p. 75; Valentino, 2004, p. 395). Leaders need to be committed to the organization's vision, values, and mission to communicate it to others and connect it to a sense of meaning and purpose (Cummings, Hayduk, & Estabrooks, 2005, p. 3; Bennis, 1999, p. 77; Gragnolati & Stupak, 2002, p. 78; Schwartz, & Tumblin, 2002, p. 1420). Vision is essential because it generates the energy necessary to produce action that leads to success. However, having a vision without a core sense of shared values does not work; the organization's vision and values pull everyone together (Gragnolati & Stupak, 2002, p. 79; O'Toole, 1995, p. 11; Perra, 2001, p. 72). Setting a vision instils hope, reassurance, and inspiration in others, and culture embodies the organization's visions and values. There is a link between the organization's vision and values, and both guide actions that support the organization's purpose and meaning (McEnroe, 1995, p. 6; Pendleton & King, 2002, p. 1352). Values become the foundation for trust, respect, inspiration, innovation, and commitment (p. 1354). They flow from the leadership of the organization and are determined by their most deeply held beliefs. According to Kuczmarski and Kuczmarski (1995), people must have the conceptual framework of shared values that will become the ethical framework that guides everyone's activities and behaviours (p. 52), and the organization's and the leader's values must be aligned. Likewise, the organization's and the followers' values must be congruent because discordance leads to dissatisfaction and decreased quality (McNeese-Smith & Crook, 2003, p. 268; Torangeau & McGliton, 2004, p. 183; Torfino, 1995, p. 45). Values-based leadership requires reflection and introspection as well as a consciousness and self-awareness of how the leader's behaviour reflects their words (Howatson-Jones, 2004, p. 23; Kuczmarski & Kuczmarski, 1995, p. 58). Leatt and Porter (2003) pointed out that empowering others, creating meaning, thinking reflectively, and communicating are important roles of leaders (p. 17). Furthermore, according to Kuczmarski and Kuczmarski, leaders foster values, ideals, morals, and a sense of purpose in others; and the role of the leader is to communicate these organizational values to all employees of the organization (p. 210) and to use the values taken from the mission statement and other organizational documents during strategic planning (Gosling & Mintzberg, 2003, p. 58). Leaders empower others, create meaning, think reflectively, and communicate clearly (Valentino, 2004, p. 395; Upenieks, 2003, p. 467).

Ethics and Integrity

The second theme is ethics and integrity. Different authors spoke of similar concepts related to ethical leadership, which is inextricably linked to ethics. Ethics is the moral sense that originates in personal and professional values. O'Toole (1995) proposed that strong leaders' actions and decisions are based on ethical and caring behaviours (p. 24) and that ethical leadership positively impacts the culture and soul of the organization (p. 47). O'Toole discussed the concept of integrity related to doing right: "Integrity is evident from the fact that the long-term courses were adopted on what was morally right" (p. 24) When decisions and actions reflect these values, the followers develop trust (Gragnolati & Stupak, 2002, p. 79; Pendleton & King, 2002, p. 1352; Shirey, 2005, p. 60). The characteristics of these ethical, moral, values-based leaders include honesty, fairness, honour, respect, loyalty, trust, compassion, justice, integrity, and commitment (Howatson-Jones, 2004, p. 22). The obligation of leaders centers around preserving the organization's identity to ensure that it never loses its sense of meaning and direction (Collins, 2001, p. 75). Great leaders help followers to understand the values and vision and continually reexamine actions and decisions in light of the organization's values. Followers can comprehend and support tough choices as long as they can link them to the organization's values (Pendleton & King, 2002, p. 1353; Valentino, 2004, p. 397). Exemplary leaders, whose values are evident in their everyday actions and decisions, affect the social fabric and ethics of the entire organization. Ethical leaders do the right thing for the right reasons for the good of the organization and staff (Bass & Steidlmeier, 1999, p. 211; Perra, 2001, p. 70). If leaders act ethically, they foster a sense of trust and respect from their followers (Bennis, 1999, p. 78; Bruhn, 2004a, p. 6); leaders' actions and decisions are based on ethical and caring behaviours (Shirey, 2005, p. 60).

Service and Inspiration

Service and inspiration was the third theme. A great leader has the ability to nurture people and believes that everyone has intrinsic value and worth. True leadership should benefit the follower (O'Toole, 1995, p. 14). Leaders who address followers' needs instil loyalty to the organization, and leaders who meet the needs of followers enable and empower them to serve others. 'Servant leaders' support, protect, guide, remove barriers, and provide resources for their followers (Howatson-Jones, 2004, p. 23). Similarly, 'values-based leaders' use active listening skills, they understand people, and they demonstrate respect and empathy. The most critical role of a values-based leader is to recognize the potential of each individual and treat everyone with respect and dignity (Schwartz & Tumblin, 2002, p. 1421). Self-awareness allows a leader to comprehend employees' worldviews and values and thus understand their motives (McEnroe, 1995, p. 6).

Howatson-Jones (2004) emphasized that empathy and recognition are key to the leader's ability to engage staff (p. 23) and that empathy is an important foundation for building respectful relationships that are based on collaboration and cooperation (p. 23) and enable the leader to empower followers (Leatt & Porter, 2003, p. 17). Great leaders know that people are their greatest asset, and leaders need to be authentic and accountable and act with integrity to enable staff to move in the same direction as the organization (Bruhn, 2004b, p. 133; Cummings Hayduk & Estabrooks, 2005, p. 9). This is accomplished by ensuring that the staff understand the organization's values and the meaning and purpose of their work (Bennis, 1999, p. 77). Staff will find their own personal values in their work and know that they make a difference (Upenieks, 2003, p. 467). Although the leader must be able to inspire others to commit to the vision, mission, and values of the organization, it is more about being an inspiring leader than it is about telling others to be inspired. (Secretan, 2004, p. 2).

According to Secretan (2004), the ability to inspire "is an act of service that flows from love" (p. 211). The leader connects with each individual's values and helps him/her to understand how his/her values and needs fit with those of the organization. Leaders lead by modeling and do not ask others to do anything that they would not do themselves. Great leaders exist for the benefit of the organization and through the service and inspiration of others to ensure the future of the organization (Collins, 2001, p. 9). Service is what leaders do for the staff, organization, and the community; and leaders inspire people through encouragement and commitment based in relationship (Dunham-Taylor, 2000, p. 248).

Legacy

Legacy is the final theme identified in the literature. Pendleton and King (2002) stated that research studies have demonstrated that organizations with clear vision and values outperform other comparable organizations whose vision and values are not clear (p. 1352). Organizations with long-term profitability and survival have a strong orientation to values and have developed a culture that supports the values (p. 1352).

Also, values-based leaders realize that the organization's destiny is not entwined with their own and in fact act to secure the organization's legacy (Collins, 2001, p. 3). These leaders cultivate and mentor other great leaders (Bennis, 1999, p. 77). They engage in long-term thinking by developing succession plans to position the organization 10 years into the future. As Secretan (2004) stated, great leaders focus on people and help them to see a better future and move toward it (p. 160). Leaders significantly impact the moral behaviour of their followers by articulating and demonstrating behaviour that is consistent with the interpretation of the organization's values and vision (Bruhn, 2004b, p.135). They work to ensure that core values are woven into the social fabric or culture of the organization so that they will endure long after the leader has gone (Collins, 2001, p. 75). Leaders ensure that their organization's culture remains intact and continues to be reinforced even after people leave (Bruhn, 2004a, p. 9).

Chapter Summary

The majority of the research on leadership is descriptive and perception based. The literature search conducted for this thesis revealed little research that directly addresses the subject of values-based leadership. Much of the published literature can be categorized opinion based. Of 52 citations selected for review, 4 were level 1 research, 4 were level 2 research, and 18 were classified as nonresearch. The literature emphasized a need for synchronicity between the leader's and the organization's values. The tasks of leaders include defining goals, inspiring, fostering collaboration and cooperation, explaining, and affirming the organization's values. The hallmark of values-based leadership is communicating the vision and values of the organization and acting in congruence with these values. Shared, affirmed values make for healthy work environments; hence the importance of this type of leadership style. Four recurring themes were identified from the literature on the topic of values-based leadership: vision, values, and mission; ethics and integrity; service and inspiration; and legacy.

Because support for the concept of values-based leadership was found in this context, it was determined that an exploratory descriptive study was an appropriate starting point to conduct the research on values-based leadership. The themes on values-based leadership that were identified in the literature were used to develop a deductive coding framework for the secondary analysis of LINCS's interview data that is reported in this thesis. The research method is discussed in detail in the next chapter.

CHAPTER THREE:

METHODS AND PROCEDURES

Exploratory descriptive study designs are appropriate for use for hypothesis generation for further studies when there is limited knowledge on a topic or the population being studied (Brink & Wood, 2001). This approach was used in this study to examine an integration strategy in the Saskatoon Health Region. Semistructured interviews with past and present leaders in the Saskatoon Health Region between 1995 and 2005 had been conducted as part of the nationally funded LINCS Research Program, which focused on continuity of care. As a student research partner in this study, the author of this thesis conducted these interviews. Consent was obtained for secondary analysis of the data at the time of the interviews. Subsequently, the interview transcripts were analyzed to answer the following guiding questions for the thesis:

1. What are the leadership characteristics, behaviours, and values of the past and present healthcare leaders in Saskatoon who developed, implemented, and maintained the partnership agreement between St. Paul's Hospital and Saskatoon Regional Health Authority?
2. Do these characteristics, behaviours, and values suggest a leadership style?

Data Sources

Data from documents and semistructured interviews helped to answer the research questions.

Approach to Analysis of Documents

Thirteen documents were examined to prepare for the interviews and to assist in interpreting the interview data. The LINCS research team identified some of the documents, and the informants identified others. The documents retrieved for the study are summarized in Table 5 in chronological order. Eleven of the 13 documents were read prior to conducting the interviews to identify contextual and chronological factors; 2 documents were produced by the organizations after the interviews were conducted. A second reading of all 13 documents provided the opportunity to validate the comments from the interviews.

Table 5

Chronological Catalogue of Documents

Date	Title	Topic area
April 16, 1996	Letter to Honorable Roy Romanov, Premier of Saskatchewan, and Honorable Eric Cline, Minister of Health from, board chairs	Announcement of partnership agreement and Principles guiding SPH – Saskatoon District Health Joint Services Management
April 18, 1996	SPH – Saskatoon District Health Joint Service Management Partnership	Original partnership agreement outlines the purpose, principles, operations, financial and program services management, dispute resolution, terms of the agreement, option of termination processes of the partnership agreement.
April 18, 1996	Media Release	Public announcement of partnership between Saskatoon District Health Board and SPH Board of Management
July 26, 1996	Viewpoint: SPH & District Health Board - a partnership that risks change to add value an improve health	Letter to manager, editorial page of *The StarPhoenix* from board chairs. Response to public fears about SPH and allocation of health services
August 8, 1996	Decision Framework: Shared Service Committee	Describes framework for joint decision-making and conflict resolution. Delineates the ethical framework and the guiding values.
1996	Overhead presentation on the Joint Service Management Partnership	Education package delivered by the CEOs to staff on goals, 12 guiding principle, integrated management structure, and benefit of the integrated approach
Spring 1998	Article published in the CHAC Review	A case study of the restructuring and reform that occurred in Saskatoon

(table continues)

Date	Title	Topic area
March 12, 1998	Saskatchewan Health Chronology of Events 1992-1997	A chronological listing of important events and dates in Saskatoon including regionalization and implementation of partnership agreement
July, 2002	Affiliation Agreement Between SPH (Grey Nuns) of Saskatoon and Saskatoon District Health (2002a)	Contract outlining SPH governance and the Clinical Services Accountabilities.
July, 2002	Memorandum of Mutual Understanding and Intent (SRHA & SPH, 2002b)	Affiliation Agreement amended to include the Guiding Principles for the Joint Service Management Partnership.
March 31, 2004	Health Status Report, Saskatoon Health Region (2004)	A 95 page report compiled by the Chief Medical Health Officer and Public Health Services department of the Saskatoon Health Region.
May 14, 2005	Regionalization – National Perspectives for Catholic Health Care	The power-point presentation of a paper presented at the National Catholic Health Care Association of Canada Annual Conference. Outline regionalization and the St. Paul's experience.
September 12, 2005	Funding Agreement Between SRHA and SPH (2005a; Grey Nuns) of Saskatoon	Contract outlining the terms, administration, confidentiality, termination or amendments, and dispute resolution processes.
September 12, 2005	Partnership agreement between SRHA and SPH (2005b; Grey Nuns) of Saskatoon	Outlines the purpose, principles, operations, financial and program services management, dispute resolution, terms of the agreement, option of termination processes of the partnership agreement.

Semistructured Interviews

The purpose of the original LINCS research was to describe an administrative integration strategy used in the Saskatoon Health Region. Semistructured interviews where conducted with past and present board chairs, CEOs, and other leaders of the SRHA and SPH. Fifteen interviews transcribed verbatim comprised the data set. The study reported in this thesis is a secondary analysis of the interview data conducted to describe the leadership characteristics, behaviours, and values of health care leaders in Saskatoon between 1995 and 2005.

Identification of Informants

A primary informant known to the researchers was one of the leaders responsible for the development and implementation of the partnership agreement. This individual had continuing contact with past and present leaders in Saskatoon and identified board chairs, CEOs, and other key leaders in the Saskatoon who had been involved in the development, implementation, and maintenance of an integration strategy referred to as the partnership agreement. She telephoned each potential informant and asked, first, if they were interested in being interviewed for the LINCS study and, second, if she could provide their name and contact information to the researchers. Once she had ascertained the potential informants' interest and obtained their permission, she gave the researchers the contact information. The primary informant was subsequently not aware of who had agreed to participate in the research.

The Interview Sample

Board chairs and CEOs were identified by position. Four out of five past and present board chairs and six out of six past and present CEOs participated. The primary informant recommended an additional five individuals who had participated in the implementation of the partnership agreement. Although they do not constitute a complete sample of organizational leaders involved in the implementation, these five individuals represented a variety of senior positions, including a senior physician, two vice presidents (VPs), a general manager (GM), and a representative of the Grey Nuns Organization (the original owners of SPH).

The Interview Guide

Investigators in the LINCS research program developed the semistructured interview guide, which consisted of 39 questions (Appendix A). These questions were given to the informants in advance of the interviews.

The Interview Process

The researchers contacted the potential informants by phone and confirmed their interest. Packages containing the study purpose, interview questions, information letters, and consent forms (Appendix C) were sent via email to the informants, who then confirmed their willingness to participate. Following delivery of the information, the researcher made a second phone contact to answer questions and set up interview dates and times. Fifteen interviews were conducted between May and September 2005, 12 in person and 3 by phone. There were no noticeable differences in the response patterns between the phone interviews and the in-person interviews. For those interviews conducted in person, informed consent was obtained at the time of the interview. For the three phone interviews, the informants were asked to fax a signed copy of the written consent to the researcher, verbal informed consent was audiotaped at the beginning of the interviews, and the informants had the opportunity to ask questions. The interviews lasted between 30 and 90 minutes.

Approach to the Analysis of the Data

The verbatim transcripts of the audiotaped interviews were content analyzed by using QSR NUD*IST revision 6 software and a three-level coding process. A two-step deductive coding structure was developed using the responses to the questions on leadership in the semistructured interview guide (Appendix A) and themes from the literature on values-based leadership. In a third level of analysis, an inductive approach was used to identify any additional common themes.

Deductive Analysis

Polit and Beck (2006) described the use of predetermined themes for the content analysis of exploratory descriptive research. In this research, a two-step deductive approach was developed to code the interview data. The first step of deductive coding involved the responses to three questions on leadership from the original semistructured interview guide (Appendix A):

1. How did leadership characteristics and behaviours and values impact the planning of the agreement?
2. How did leadership characteristics and behaviours and values impact the implementation of the agreement?
3. What kind of values and leadership characteristics and behaviours do people need to work in this structure?

The definitions of leadership behaviours and characteristics were selected from the leadership literature to categorize the informants' responses to the three questions. *Behaviours* are defined as "particular acts in which a leader engages in the course of directing and coordinating the work of his group members" (Bass & Stogdill, 1974, p. 14), where *characteristics* are the traits or qualities expected in a leader (Kouzes & Posner, 2002, p. 24). These definitions were used to categorize the informants' answers to the three leadership questions in the interview guide as behaviours or characteristics. Once this initial categorization was completed, each interview transcript was reviewed in its entirety for references to the behaviours and characteristics that had been identified in the responses to the three questions. The resulting list of behaviours and characteristics was compiled in a series of frequency tables.

In the second step of deductive coding, the four themes identified in the literature on values-based leadership were used to further group the behaviours and characteristics. Support for each of the four themes derived from research, expert opinion, theoretical frameworks, and models of leadership is illustrated in four tables presented in Appendix D. These tables summarize the authors, dates, and titles of publications in which each of the four themes is discussed. This use of a deductive approach was intended to address the potential for informant or interviewer bias.

The four deductive themes used in the coding process helped to relate many of the behaviours and characteristics identified in step 1 to the themes of vision, values, and mission; ethics and integrity; service and inspiration; and legacy that had been identified in the literature. When these leadership behaviours and characteristics were coded using these themes, many, but not all, of the behaviours and characteristics fit with one or more of the themes.

Inductive Analysis

The creation of the third inductive coding step addressed the need for flexibility and revision that Polit and Beck (2006) recommended. An inductive approach was used to incorporate the responses that did not fit into the previously identified deductive categories. In step 3 the data on behaviours and characteristics that did not fit into one of the four themes were reexamined; the behaviours and characteristics that more than two informants had identified were compiled in tabular form.

Ethical Considerations

Ethical approval was obtained from the University of Alberta Health Ethics Board Panel B and the University of Saskatchewan Behavioural Research Ethics Board for the original LINCS Program of Research on Implementing Integration Strategies. The original consent contained a statement that the data would be used for secondary analysis, and this secondary analysis of the original data to examine leadership characteristics, behaviours, and values received ethics approval from the University of Alberta Health Ethics Board Panel B on July 27, 2006.

At the time of the interview the participants were informed that a graduate student interested in values-based leadership would use the data for secondary analysis. All interviews were audiotaped; in addition, the researcher took notes at the interviews. All interviews were transcribed verbatim by a clerical assistant familiar with this process and reviewed by the researcher for accuracy. Once reviewed, each informant was provided with a copy of his/her transcript and given an opportunity to edit or clarify statements. Two participants made some minor edits by removing comments about easily identifiable people. Each audiotape was copied to insure against loss or accidental erasure. The audiotapes, notes, and consents are secured in a locked filing cabinet in the researcher's home, where they will be kept for the required five years.

Research Implementation

The interview informants for the LINCS research program were identified in January 2005, and the interviews were conducted between May and September 2005. The original data analysis for the purposes of the LINCS research program was conducted between November 2005 and March 2006. The findings pertinent to the LINCS research are being incorporated into the final report of the study and will be submitted for publication in the periodical literature.

The secondary analysis described in this proposal was conducted in August 2006 once ethical approval was obtained from University of Alberta Health Ethics Research Board Panel B.

Chapter Summary

This thesis reports on the data from two sources of research. Thirteen documents were read to inform the context and chronological order of events and to verify the contents of the interviews, and 15 semistructured interviews were conducted. Four out of five board chairs, all six CEOs, and five other senior leaders were interviewed for their insights into the 10 years of interest in this study.

An analysis of 11 documents enabled the identification of contextual and chronological factors in preparation for the interviews. All 13 documents were reread during the analysis of the interview data to confirm facts or impressions. The interview transcripts were content analyzed using two deductive and an inductive coding step. Step 1 involved (a) selecting definitions of leadership behaviours and characteristics from the leadership literature, (b) identifying behaviours and characteristics from three interview questions that dealt directly with leadership, (c) rereading the responses to *all* of the interview questions and adding other references to the behaviours and characteristics that the informants made in response to the three questions on leadership, and (d) compiling frequency tables of all identified behaviours and characteristics. Step 2 entailed examining all behaviours and characteristic identified in step 1 for fit with the four themes that had been identified in the literature on values-based leadership. Step 3 included reexamining the behaviours and characteristics data that did not fit into one of the four themes for additional common themes. The findings of this study are presented in the following chapter.

CHAPTER FOUR:

PRESENTATION OF THE FINDINGS

In this chapter the findings from the analysis of documents and interview data are presented. Contextual and chronological facts identified through document analysis are discussed in narrative form. The personal and demographic characteristics of the interview informants are also presented. The findings from the interview data appear in tabular form. First, behaviours and characteristics are discussed in relation to the frequency with which they were mentioned; and second, the behaviours and characteristics are discussed in relation to four themes identified from the published literature pertaining to values based leadership. Finally, results of an inductive analysis of the interview transcripts is presented.

Analysis of Documents and Contextual Factors

A total of 13 documents were examined to identify or corroborate contextual and chronological facts. The documents were identified by date, title, and topic area in Table 5; and these facts were used to create the following narrative descriptions.

The integrated partnership agreement created in 1995 helped to outline a new way for SRHA and SPH to work together. The premise for the partnership agreement was the development of a strategy to improve healthcare services through integration and coordination and to maximize the benefits to the community. The goals were to create a seamless continuum of care; to improve resource utilization by avoiding unnecessary duplication; to improve planning, coordination, and accountability for services; and to enhance the ability of each board to fulfill its vision and mission (Skene, 1996, 1998). Twelve guiding principles (Appendix B) were developed as the foundation for the partnership agreement and remain in place today. Four key features of this partnership agreement make it unique compared to other affiliation agreements throughout Saskatchewan and nationally.

The first feature of note was that 12 health service groups were organized to create the main framework for the integrated model of care (Wagner & Donlevy, 1996; Letter to Premier and Minister of Health, 1996). SRHA and SPH divided the management of the care groups between them. The original integrated model that identifies the care groups and responsible organizations is illustrated in Appendix E. The is only one senior executive management team, which is comprised of the CEOs and VPs of both SRHA and SPH. However, the maintenance of separate boards for both organizations is important, and the CEOs report to their respective boards (Skene, 1996; Wagner & Donlevy, 1996).

The second key feature was the formation of a Shared Service Committee that consists of the executive of both boards and both CEOs. Any decision making or conflict resolution occurs in this committee. This, in fact, created a formal forum for board-to-board discussions (SDH & SPH, 1996).

It was important to the SPH board that the mission and values be maintained to continue its Catholic ministry and remain true to its founders (Skene, 1998). Human resources became an integrated program managed by the SRHA, and all senior executives, except SPH's CEO, became SRHA employees. The third key feature was that SPH-based managers and frontline staff remained SPH employees, which was critical for SPH to ensure that the staff would be orientated and committed to SPH's values and mission (SDH & SPH, 1996).

The fourth key feature was to have one integrated finance department for the whole region, which is unheard of in other affiliation agreements. The finance department was to be managed by SRHA, with the VP of Finance attending the board meetings of both SRHA and SPH. Although accountability to the government was solely SRHA's responsibility, SPH was accountable to SRHA for the finances of the programs that it managed. The philosophy behind this was that because SRHA receives the money from the government, SRHA would assume all financial responsibility and accountability to the government and would absorb all of SPH's deficits and surpluses (SDH & SPH, 1996).

The partnership agreement and its key features were unique and nontraditional compared to what was happening across Canada. It was necessary to move from a competitive environment to one of collaboration to consolidate acute care services (Wagner & Donlevy, 1996). The leaders were aware of what was happening in other parts of the country and believed that there was a better way; moreover, the size and scales of economy for Saskatoon made an integrated model attractive (Fitzgerald, 2005; Skene, 1998).

Implementation of the partnership agreement took several years, and there were changes in CEO leaders in SRHA during the process. Fortunately, the new CEO had been involved in the process, and the leaders were able to keep the change moving. Some of the integration strategies had started to be implemented prior to the partnership agreement (Skene, 1998). For example, the consolidation of obstetrics and ophthalmology occurred before 1996. As described earlier, even though the relationship between the two organizations was tense and competitive, past leaders had started much of the groundwork. One of the first processes to be implemented was the joint leadership meeting between SPH and SRHA senior executive teams; at the same time, joint board meetings were also being held. Eventually, a shared governance committee was created that consisted of both CEOs and both board Executive Committee members (Wagner, 1998; Wagner & Donlevy, 1996).

The implementation faced challenges, some of which continue today. A particularly recurring hot topic is the issue of corporate identity. The continuation of St. Paul's mission and values is the second guiding principle (Appendix B), and central to that is its visual identity, including logos (Fitzgerald, 2005; Skene, 1998).

Another challenge was to determine which care groups SPH and SRHA would each manage. A high-profile service needed to be managed by SPH to ensure the legitimacy of the partnership. To this end, SPH was given the lead on Emergency Services. Appendix E lists the original care groups that each organization led. Although maintaining the mission and vision was important to SPH, the one concession that was important to SRHA was control over the finances. This was significant because some members of the SPH board and senior team saw this as giving up control. It was initially a challenge but eventually became an event that facilitated the implementation of the partnership agreement (Skene, 1996, 1998).

Another challenge surfaced with the medical staff: Some did not want to be integrated and have to admit to all hospitals (Wagner, 1998). A final barrier was the provincial government (Saskatchewan Health), which was not comfortable with a nontraditional agreement. Negotiations over re-signing the partnership agreement for another 10 years was a problem in 2005 again because the partnership agreement did not fit the government's standard template. Therefore both a financial agreement and the partnership agreement were signed (the funding agreement; SRHA & SPH, 2005a). Even with the challenges, this partnership agreement works because of the focus on community service. Respect and trust developed in the relationship as a direct result of the leaders' decisions that were directed by community needs (Skene, 1998).

Fortunately, many facilitators were identified that helped the process. The first were the guiding principles that were the groundwork of the partnership (Skene, 1998; SRHA & SPH, 1996). The majority of restructuring and job losses occurred at the VP and GM level. The elimination of duplicate positions meant that employees from both organizations were applying for the same positions, but this turmoil did not impact those in manager and frontline positions. Both CEOs and the medical chief of staff were involved in the interview and selection process for all positions (Skene, 1996). During the entire process the emphasis was on the importance of relationship and communication. An outside consultant was hired to work with the boards and senior executive team to help them understand what being interdependent meant in the context of the partnership agreement (Wagner, 1998).

The relationship has improved significantly since the implementation of the partnership agreement. There was strong recognition that the leaders, CEOs, and board chairs in Saskatoon in the early to mid 1990s set the stage for the change in relationship and the development of a true collaborative partnership. The relationship continues to develop and redevelop as leaders within the system change. Although the relationship is now a positive one, it takes a great deal of work to maintain. The foundation of this good relationship was and continues to be communication (Fitzgerald, 2005). Communication board to board, CEO to CEO, and within the senior executive teams is the reason for the relationship's success today.

However, SPH has to work harder at maintaining the relationship. A problem is that all of the VPs are SRHA employees even though they have all managed care groups that belong to SPH and report to SPH's CEO as well as SRHA's CEO. This presents problems for the next level of management, GMs and managers, who are not always clear on the reporting structure to SRHA's CEO. With no VP assigned to SRHA, this could have critical repercussions for the survival of SPH because it could potentially impede succession planning (Fitzgerald, 2005; Skene, 1998).

As with all relationships, nothing is perfect. There continues to be challenges with the integration of frontline staff who are not as committed or who do not have a solid understanding of the relationship. It was important to SPH to maintain the mission, vision, and values that were a part of its Catholic identity; this was built into the guiding principles (SRHA & SPH, 1996). This continues to be respected and has enabled three separate cultures to prosper in the acute care setting. Paradoxically, this is both a strength and a weakness of the partnership agreement. With diversity there will always be comparisons and loyalty to one's 'own,' yet there is strength in the creativity and innovation that different cultures bring to the table (Fitzgerald, 2005).

The historical and political context had already been established to enable the parties to consider the novel approach outlined in the partnership agreement (Wagner & Donlevy, 1996). What is also abundantly clear is that this is a relational model, and without the continued focus on relationship and communication, the implementation of the partnership agreement would not have succeeded (Skene, 1998). The focus on relationship and communication is another strength and weakness of this model. It is important to acknowledge the significance of the leaders at the time of the development and implementation of the partnership agreement. This was a group who believed in interdependence and collaboration. Both SRHA and SPH had to relinquish power and control, something that is hard for leaders to do, and this model will succeed only with certain styles of leadership (Skene, 1998).

In September 2005 the integrated partnership agreement was renegotiated for another 10 years. Some of the responsibilities for managing programs have been realigned, but the original guiding principles remain intact (SRHA & SPH, 2005b). No formal evaluation of the integrated partnership agreement has ever been conducted; however, 10 years later this integrated approach has resulted in better access, improved resource utilization, and a regionwide interdisciplinary approach to health service planning, development, delivery, and quality monitoring. Interdependence and recognition of the unique and diverse contributions of SRHA and SPH have been achieved with a complementary vision for health in the Saskatoon region (Skene, 1998).

Analysis of the Interview Data

The interviews conducted for the LINCS program were designed to identify contextual factors and leadership approaches related to specific service integration strategies in the health region. For the purposes of this secondary analysis, a thematic analysis was conducted with three levels of coding based on the questions in the interview guide on leadership characteristics, behaviours, and styles; the partnership agreement integration strategy in Saskatoon, Saskatchewan; the literature on values-based leadership; and themes identified in the interviews but not anticipated in the literature.

Using this process allowed the researcher to identify areas of agreement between the informants' descriptions of leadership characteristics and behaviours and the literature on values-based leadership.

Characteristics of the Informants

As stated earlier, interviews were conducted with 15 past and present senior officials of SRHA and SPH. The informants' characteristics and demographics of position, corporation, timing, and gender are summarized in Table 6. The gender included 10 females and 5 males. The corporation included 8 informants affiliated with SPH and 7 affiliated with SRHA. The positions included 4 board chairs, 6 CEOs, 3 VPs, 1 GM (combined under the heading VP), and 2 others. The timing included 7 of the informants described as *present*—currently involved in either SRHA or SPH—and 8 informants describe as *past*. Of these present informants, 5 had been employed in Saskatoon at the time that the partnership agreement was implemented in 1995. The professional affiliation included 9 nurses, 1 physician, 1 educator, 1 with human resources, and 3 with business backgrounds.

Findings From the Deductive Analysis

A two-step deductive approach to coding the interview data was developed for this research. First, a definition of leadership behaviours and characteristics was selected from the leadership literature for use in categorizing the informants' responses. Second, four themes identified in the literature on values-based leadership were used to further group the behaviours and characteristics.

Table 6

Characteristics of Informants

	SPH affiliated	SRHA affiliated	Total
Gender			
Female	7	3	10
Male	1	4	5
Total	8	7	15
Position			
Board chair	2	2	4
CEO	3	3	6
VP and GM	2	1	3
Chief of staff		1	1
Other	1		1
Total	8	7	15
Participation			
Present	4	3	7
Past	4	4	8
Total	8	7	15
Professional affiliation			
Nursing	6	3	9
Business	1	2	3
Education	1		1
Medicine		1	1
Human Resources		1	1
Total	8	7	15

Analysis of Behaviours and Characteristic

The interview data were initially analyzed using the informants' responses to questions about the characteristics and behaviours of the past and present healthcare leaders in Saskatoon who developed, implemented, and maintained the partnership agreement between SPH and SRHA. If more than one informant identified the behaviour or characteristic of a leader, it was coded for analysis using the definitions from the leadership literature.

The informants identified 39 different attributes of leaders, 26 of which were described as leadership behaviours and 13 as leadership characteristics. The behaviours and characteristics are presented in a series of tables beginning with the behaviours (Tables 8 through 10), which are clustered into groups based upon the frequency with which they were mentioned. A similar approach was taken to grouping and presenting the leadership characteristics in Tables 11 and 12.

Leadership behaviours. The 26 behaviours that the respondents identified are reported in a series of frequency tables of the total number of respondents and further broken down into position, corporation, timing, and gender. All quotations are verbatim as transcribed from the audiotapes; however, to maintain anonymity, identifying names or genders have been replaced with *he/she* or *him/her*.

Thirteen to 15 of the informants mentioned the six top behaviours summarized in Table 7 in descending order of frequency: acting collaboratively, communicating openly, maintaining sustainability, living with change, using power, and serving the community. The only inference that can be made from these top six behaviours is that the majority of the informants agreed that these are the leadership behaviours that past and present leaders in Saskatoon have demonstrated.

1. Acting collaboratively: All 15 informants spoke of the need to work collaboratively and cooperatively for the integration strategy to be successful. They described collaboration as acting interdependently and in partnership and the style of leadership as relational. The informants spoke of collaboration as something that

Table 7

Summary of Top Six Behaviours

Leadership behaviours	Total informants	Chair	CEO	VP	Other	SRHA	SPH	Past	Present	Female	Male
1. Acting collaboratively	15	4	6	3	2	7	8	8	7	10	5
2. Communicating openly	15	4	6	3	2	7	8	8	7	10	5
3. Maintaining sustainability	14	4	5	3	2	6	8	8	6	9	5
4. Living with change	13	4	5	2	2	6	7	6	7	9	4
5. Using power: influence vs. control	13	4	6	2	1	5	8	7	6	9	4
6. Serving the community	13	4	6	2	1	5	8	7	6	9	4

organizations value. One board chair mused about the ripple effect of respect and encouragement once SRHA and SPH decided to enter into a partnership agreement. All informants used words such as *collaborative*, *cooperative*, *partnership*, *relational*, and *interdependence* to describe the model. Two informants stated that the organizations recruit leaders who are comfortable with a collaborative, interorganizational model of delivering care. One informant stated, "People that are coming from very cooperative, collaborative ….. committed to this kind of partnership, and so they have worked to bring in people who also commit to this kind of partnership." Foundational to a collaborative model is open, honest communication. Another informant agreed:

> I think they had to value collaboration; they have that kind of transparency. Sharing of information, have to say it was a style that had to be a collaborative leadership in sense of trust, that we are in this together and not focused outside the partnership, and so . . . to get there you have to have respect.

2. Communicating openly: All informants identified the need for open, honest, and transparent communication. Several defined communicating as being willing to listen, which they considered crucial to create staff trust. They described the relationship between SRHA and SPH prior to the partnership agreement as competitive and destructive. When asked what had changed, one informant replied, "It was the communication and the open dialogue." Another informant acknowledged that communication is the foundation for the relationship:

> There's got to be a leadership style that's open, that's not game playing, that's transparent. When I say *open*, I mean frank, honest, . . . not cards-up-sleeve foolishness. When I say *transparent*, I mean explaining, having that kind of transparency; sharing of information—you know, openness. There's just no holds barred . . . . And so that had to be open and transparent so that the trust could be [created]. We have to be open in sharing information; you have to be transparent . . . . Are we prepared to share the good and the bad openly?

3. Maintaining sustainability: Fourteen informants talked about sustainability, especially for SPH, and some referred to succession planning. One past CEO from SPH articulated the issue:

> [We need] a model in place which needs to be vested in the organization and not in the individual because it has to go forward even if you are not there and you have different people coming in. How do you put the structures in place, that they are there and the model will continue? . . . I think what was really important to St. Paul's besides the mission is that they survive! And that they survive with vibrancy into the future.

The informants identified succession planning as vitally important, especially for SPH. One informant talked about the importance of educating employees, board members, and the national healthcare community about the partnership agreement:

> There needs to be education on, What does a partnership mean? Which is, I think, critical. And two, because it's unique across Canada, it's not necessarily something that your average, your experienced CEO just walks into, so that the CEOs change, which means because it's such a unique relationship. And the word

> *relationship* means there's something that requires development. That's, I think, impacted a bit because people have to get to know each other and understand, What does this mean, and how do we work together?

Two different CEOs talked about the partnership's sustainability because it has survived for 10 years and endured numerous changes in leadership: "I am not there, . . . and the relationship continues, it is sustainable, and that is what sustainable is in my estimation. It is not just built on personalities, although the personalities are very important in the early stages." One informant spoke of follower buy-in as the reason for the success of the partnership agreement: "Absolutely, I think that it is. As people have experienced it and people have changed, some of the people who were responsible for maintaining the partnership have become even more committed to it based on success."

4. Living with change: The implementation of the partnership agreement was recognized as a major change initiative for both organizations. Thirteen informants considered the ability to develop a change strategy/plan as key for leaders. One informant stated that the partnership agreement is not a "static document; this has to be something that is living, growing, maturing." Several informants talked about changes related to the management of the care groups:

> And [it's] going through another iteration of the service realignment, . . . which is another big challenge. But that is relatively minor. That doesn't put the partnership in question; it just puts the individual clinical area through a bit of a change process.

Another commented, "I think that this plan is evolving and changing on a yearly basis."

5. Using power—influence versus control: Thirteen informants compared shared and participatory power to control. They described influence as a type of power that evolved once the partnership agreement was implemented:

> I don't think [he/she] is about power. It's more influence, patient care, quality of care. [He/She] used to say, "It's beyond personalities. What we plan has to be bigger. It can't be built on people; it has to be strong enough to stand as it is and to operate and to function this new system, this new model, with us or without us." And I think that's where [his/her] twelve nonnegotiables came in, how they could see this happening, and in order to attain this, there was a giving up of control, of the control, especially of the money.

The focus on influence rather than control enables leaders from both organizations to be involved in decision making and planning and everyone to have a voice at the table. The informants agreed that "it's a good model, and if you have the right people, you can make it work; and if you have people who need all the power and control and can't negotiate and compromise, it won't work."

6. Serving the community: Thirteen informants stressed that leaders need to focus on the needs of the community and the population they serve. One informant stated, "What really makes it work is the continued focus back to patients." Another informant contended that decisions have to take into consideration future needs and trends "in relation to meeting the needs of the community that we had served and would serve in the future." The informants acknowledged that the reason that the partnership agreement works is its focus on the community—"what was best for this community and what is best for the patients . . . . We are going to be taking care of the community people and not so much . . . to go forward for the benefit of residents in Saskatchewan." One informant thought that the decision on the management of a clinical service is based on what is best for the residents of Saskatoon and what makes sense operationally: "Does it make sense for the community, and does it make sense from an operational point of view? Is it an efficient way of delivering services?"

For the second set of behaviours, 8 to 12 of the informants mentioned nine, which are summarized in Table 8 in descending order of frequency. Trusting, treating fairly versus equally, living the mission, doing right, acting as a steward, acting with political awareness, being committed, being respectful, and being values driven were ranked 7-15, respectively, out of 26 according to the number of informants who mentioned these behaviours. The behaviours in this table are grouped together because some inferences can be made based on the informants' position, timing, or corporation. Inferences about gender cannot be made because the number of females was double the number of males in the sample.

Table 8

Summary of Second Set of Behaviours Ranked 7-15 out of 26

Leadership behaviours	Total informants	Chair	CEO	VP	Other	SRHA	SPH	Past	Present	Female	Male
7. Trusting	12	4	5	3	0	5	7	6	6	8	4
8. Treating fairly vs. equally	11	2	5	2	2	5	6	7	4	8	3
9. Living the mission	11	2	6	2	1	4	7	7	4	8	3
10. Doing right	11	2	5	3	1	5	6	7	4	9	2
11. Acting as a steward—allocating resources	11	3	5	1	2	4	7	7	4	7	4
12. Acting with political awareness	10	3	4	1	2	5	5	7	3	7	3
13. Being committed	8	1	4	3	0	6	2	3	5	6	2
14. Being respectful	8	2	4	1	1	6	2	5	3	5	3
15. Being values driven	8	2	4	1	1	3	5	6	2	6	2

7. Trusting: Twelve of the 15 informants talked about trust, specifically the congruence between leaders' words and actions, and about how essential but fragile trust was at the beginning of the relationship. One informant stated, "Yes, trust was and trust is precious. It can be broken so quickly, and, I mean, trust had to develop, and so it took a while to develop." One informant stated that trust was developed through open and honest communication by "management certainly, and it had to be open and transparent so that the trust could be set, like 'We are working, we are advocates for you, we are trying to do the best.'"

8. Treating fairly vs. equally: Eleven informants described the concept of equality in terms of inclusiveness and fairness. It is interesting to note that seven of the possible eight informants from the past spoke about fairness. This may reflect the turbulent competitive climate that existed prior to the implementation of the partnership agreement and the need to eliminate duplicate positions. Decisions that were rational were seen as more important than treating the organizations, groups, and individuals as equals. One informant stated that it was "about process and not about the final decision, and so [he/she] wanted the process to be as fair and as transparent and open as possible." Another informant also talked about decisions and the decision- making process: "It is clear to everybody that it is done in as fair and rational fashion as possible."

9. Living the mission: Eleven informants spoke of the importance of an organization's mission and the need for the leader to live the mission in words and actions. All six CEOs, seven of eight past leaders, and seven of eight SPH-affiliated leaders talked about living the mission. This finding was expected because it is congruent with the guiding principles in the partnership agreement. The second principle involves

continuation of the Grey Nuns' mission and values. One informant was passionate "that, had mission, vision, values, living, breathing, actualized, every mission would have to be alive and not just on the wall." Another informant talked about SPH's mission being central to decisions about which clinical services it would manage: "Okay, what would be our role? And in defining what type of services in collaboration with the health district that would fit within our mission and our values." A second informant agreed and stated that the mission was valuable in decision making: It "strengthened the decisions that we made as an organization, in my estimation, and made them better decisions, and that helped."

10. Doing right: Eleven informants talked about the need to do the right thing for the right reasons. Seven of eight possible past informants and five of six CEOs identified doing right as a leadership behaviour. Four informants—three of them from SPH—referred to "doing right" as acting ethically or doing the ethically responsible thing. One informant stated:

> The amount of time that it took was just incredible, but we had to do that to engage the people to say, "Yes, it is the right way to do it." I mean, . . . in some areas it was a win-loss and in some areas it was a win-win, but we realized that when we looked at it and kept our objectives in mind about integrating, being an interdisciplinary organization across the continuum, we always had to keep those goals in mind.

Some of the informants referred to the ethical framework that was created for decision making and dispute resolution. One informant confirmed that the process was clearly outlined: "Acknowledge the issue. What is the situation? Define the opportunity. Specify constraints."

11. Acting as a steward—allocating resources: Eleven informants identified acting as a steward as both a value and a leadership behaviour. Seven of eight past

informants, seven of eight SPH-affiliated informants, five of six CEOs, and three of four board chairs identified this behaviour. Again, this finding was expected because the creation and implementation of the partnership agreement were driven by the need to increase efficiency and eliminate duplication. The following are excerpts from three informants that demonstrate the leaders' thought processes with regard to stewardship:

> Well, I think probably that one of the key values or drivers that I see is stewardship. So stewardship was a real driver here to try to make this thing work and get the best care possible for the people that we were serving, because there just wasn't money to toss around. And that was the whole goal: a better service to the community. I think it is a cost-effective model.
>
> For consumers this will mean better access and coordination. For health service providers it will mean physicians, nurses, counsellors, resource staff, volunteers, and community organizations all working together. It will be more convenient for them for productivity and better use of the people who contribute to health to work together and the partnership.
>
> For patients and consumers, better access and coordination; for service providers, more congruent, more convenient productivity; district-wide interdisciplinary approach to health services. I think it was a very unique way of offering services in an integrated way that certainly would reduce duplication and, hopefully, improve patient care.

12. Acting with political awareness. Ten informants spoke of the political environment and suggested that leaders need to have political acumen and the ability to read and make sense of the environment. Three of the four board chairs, four of the six CEOs, and seven of eight past informants identified this behaviour. As previously discussed, the political environment at the time of the creation and implementation of the partnership agreement was highly charged. One informant explained how decisions had the potential to have political ramifications if SRHA and SPH's relationship had not been positive:

> And if you didn't have a solid relationship— . . . because it is such an emotional issue, obstetrics is such an emotional issue, as many issues are in health . . . —that would have become an election issue, and there was an attempt to make it an election issue by some people. But the bishop and… staff at St. Paul's said, "This is the right thing to do."

One SRHA CEO spoke of the need for SPH leaders to make decisions to ensure that the hospital would not be closed. They "recognized that you either evolve and change [laughs] or you die, right?"

13. Being committed: Eight informants identified the need for leaders to be committed to the partnership agreement to sustain it. It is interesting that six of eight informants were SRHA affiliated and that four of the six CEOs and five of the seven present informants mentioned being committed. This finding was also expected because the partnership agreement is firmly established; its survival now depends on leaders' commitment to this approach. One informant described a leader as a "huge catalyst because of [his/her] desire and commitment to want to make it work and because of [his/her] relationship skills." A board chair spoke of a new CEO's commitment to the partnership agreement because of that individual involvement in the implementation, although in another role: "[He/She] had been a former member of that senior leadership team, . . . and so [he/she] already had strong commitment to a collaborative approach."

14. Being respectful: Eight informants, six of seven SRHA-affiliated informants, four of six CEOs, and five of seven past informants identified respect as essential: respect for the specific leaders who implemented the partnership agreement, the leaders' respect for each other, "respectful people, very open, honest communication," and leaders who believe in the integration strategy and have made it work. They respect diverse views and realize that these views are an integral part of relationships:

> There has to be an awful lot of respect; that's vital. There has to be respect of the region and St. Paul's, and there has to be a great deal of trust and respect by the authority members of the St. Paul's board . . . . You have to have mutual respect for the individual autonomy.

15. Being values driven: Eight informants identified the values of the organization and the role of the leader in articulating the values. Of the eight informants who spoke about the importance of values, six were past leaders, five were SPH affiliated, and four were CEOs. These findings were expected because maintaining the Grey Nuns' mission and vision was a key principle identified in the development of the partnership agreement. Two of these informants spoke of being values driven. One CEO stated:

> Whenever things got tough or you are wondering why you were doing this or it took an extra effort to keep this going it was the reason we were there. We wanted to offer the services in the way that the founders had, in the spirit of the ministry and that was key.

Another CEO noted the importance of using values to guide process: "It is hashing out and going back to the base values and principles that guide the partnership." Another informant emphasized that vision, mission, and values alignment is necessary for interorganization collaboration:

> Be really clear about what your vision, mission, and values are and what the vision, mission, and values of your partner are, and spend a lot of time to bring out how those mesh or where they don't and whether or not or where they don't is something you can live with and recognize and continue to recognize or where that is a breaking point.

Two to six of the informants mentioned 11 behaviours in the third set. These behaviours are summarized in Table 9 in descending order. Building teams, pursuing personal growth, having an individual focus, taking opportunities, being accountable, being clear, being conscious, giving support, resolving conflict, being evolutionary, and solving

Table 9

Summary of Third Set of Behaviours Ranked 16-26 out of 26

Leadership behaviours	Total informants	Chair	CEO	VP	Other	SRHA	SPH	Past	Present	Female	Male
16. Building teams	6	1	2	2	1	3	3	3	3	5	1
17. Pursuing personal growth	5	1	3	0	1	2	3	3	2	4	1
18. Having an individual focus	5	1	3	1	0	3	2	3	2	4	1
19. Taking opportunities	5	2	2	1	0	3	2	2	3	4	1
20. Being accountable	4	0	3	1	0	1	3	2	2	4	0
21. Being clear	4	1	1	1	1	2	2	4	0	3	1
22. Being conscious	4	0	2	2	0	2	2	0	4	3	1
23. Giving support	4	1	2	1	0	1	3	3	1	2	2
24. Resolving conflict	3	1	1	0	1	2	1	2	1	3	0
25. Being evolutionary	2	0	1	1	0	2	0	1	1	1	1
26. Solving problems	2	1	1	0	0	1	1	1	1	1	1

problems were ranked 16-26 as identified by the number of informants who mentioned them. These 11 behaviours are grouped together as it is difficult to make inferences because of the low number of informants who identified these behaviours.

16. Building teams: Six informants identified the need for leaders to involve the entire leadership team in the change initiative and to work with the group to build a combined team. One informant reported that team building is one of the first tasks in the

new partnership agreement: "[He/She] was very good at building a team, and I think that is my style as well." Another informant talked about hiring a consultant to help with the process of team building: "We hired a consultant out of Eastern Canada who specialized in the development of interdependent relationships."

17. Pursuing personal growth: Five informants spoke of personal growth and the need to reflect and evaluate their actions. Four of these informants thought that leaders need to be egoless "as much as that is possible in this relational model of leadership." One informant stated:

> I guess if we can see that the project is bigger than our self, . . . it helps. We can influence, we can help, and we move on; but how do we ensure that the pillars are deep? And I think that's what we are about.

18. Having an individual focus: Five informants talked about an individual focus. One suggested that this is a personal weakness and that he or she could have done more to build individual relationships: "You have to have mutual respect for the individual autonomy. Not enough done on my part to address the concerns on an individual basis. I might have been able to spend more time at the individual level." One informant who was focused on the impact of the partnership agreement at the frontline level spoke of "being there to listen to observe, to hear what they had to say, because there was a lot of uncertainty about jobs—bumping . . . . It was really not pleasant initially, but it happened."

19. Taking opportunities: Five informants spoke of the need for leaders to look for opportunities because they are important "for relationship building. Try something new; do something together."

20. Being accountable: Four informants—including three CEOs from SPH—stressed the need to be accountable and clear on what you are accountable for. They considered accountability critical in terms of leadership. With the implementation of the partnership agreement, SPH gave up control of finances:

> We had these financial accountabilities. The money comes from the government to the district, and they are accountable for every dollar that they receive. So how do we work with them so that they can meet their accountability? But St. Paul's still is a viable entity within this picture. "So how do we work with them so that they can meet their accountability . . . [so that] St. Paul's still . . . [remains] a viable entity within this picture?"

21. Being clear: Four past leaders described the need for the leader to ensure clarity in communication and in determining roles, responsibilities, and accountabilities. They stressed that lack of clarity leads to uncertainty and inconsistency. As one leader stated:

> That whole consistent common approach and vision in where we headed together piece to me was very critical in terms of leadership. Being clear on roles and accountability is very critical, so that not only CEOs and vice presidents in a more strategic operational side but in the board authority side as well. Being very clear on whose role is what and what the accountabilities are, I think, is pretty critical.

22. Being conscious: Four informants referred to *being conscious* with regard to the need for leaders to be conscious of relationships and understand the effort required to build and maintain relationships. As one informant stated, "I use the word *conscious*: It's a conscious relationship."

23. Giving support: Four informants spoke of receiving support and encouragement from their leader colleagues and the importance of it in increasing their confidence and resilience. In talking about a relationship with the board chair, one CEO stated, "That support was really important to me."

24. Resolving conflict: Three of the informants spoke of conflict management, especially in the early days of implementation, and its importance in communication. One informant gave an example of organization branding—specifically, logo use—which caused disagreement. He/she stated that the parties involved needed to "cool down and walk away." They resolved the issue by discussing policies with regard to logo use as a neutral topic—"not in the heat of the moment."

25. Being evolutionary: Two informants considered the change evolutionary rather than revolutionary. One spoke of the evolution of program integration:

> I think it was done evolutionary, not revolution; . . . for example, using a vacancy in a general manager position for medicine as an opportunity to try and do something together, and a joint hiring and a joint drafting of a new job description.

26. Solving problems: Two informants identified the need for leaders to be solution orientated. One stated, "It clearly is, persons who make this successful are those who are proven and recognized as being innovative and . . . problem solvers."

Leadership characteristics. The 13 characteristics that the respondents identified are reported in a series of frequency tables that show the total number of respondents and then further breaks them down into position, corporation, timing, and gender. All quotations are verbatim as transcribed from the audiotapes; however, to maintain anonymity, identifying names or gender are replaced with *he/she* or *him/her*.

Ten and eight informants, respectively, mentioned the top two characteristics of patience and visionary. These two characteristics are grouped together because some inferences can be made based on position, timing, or corporation. However, inferences about gender cannot be made because the number of females was double the number of males in the sample. These characteristics are summarized in Table 10 in descending order of frequency.

Table 10

Summary of Top Two Characteristics Ranked 1 and 2 out of 13

Leadership characteristic	Total informants	Chair	CEO	VP	Other	SRHA	SPH	Past	Present	Female	Male
1. Patience	10	3	5	2	0	5	5	8	2	8	2
2. Visionary	8	1	4	2	1	5	3	4	4	7	1

1. Patience: Ten informants used *patience* to describe leaders. All eight of the past leaders commented on the importance of ensuring that timing is right and communication has occurred. This finding was expected because relationships developed at the beginning of the partnership agreement. One informant stated that "patience, tolerance, the ability to identify people who were rocking the boat" are important. Another informant explained that "my little angel of serenity that he/she gave me, and I think, 'Patience, patience, patience'" helps him/her to sustain patience.

2. Visionary: Eight informants described having a vision or being visionary as a leadership characteristic. One informant thought that the vision helped to guide the change process in Saskatoon and described leaders as having the "the willingness to be bold." Two informants emphasized the importance of having a clear vision: "I would say to them, 'Develop some clarity around your vision. Be really clear about what your vision is.'" One CEO stated:

> I would say that leadership skill of cooperative envisioning and planning is very critical. A huge leadership skill related to communication in that whole telling/ selling of the new concept and consistently looking back to the beginning message needed always to be clear and consistent.

Two to six of the informants mentioned 11 characteristics in the second set. These are summarized in Table 11 in descending order of frequency. Honest, strong, visible, confidence courage, innovative, soulful, tolerance creative, passionate, and professional were ranked 3-13, respectively, as identified by the number of informants who mentioned these characteristics. They are grouped together because it is difficult to make inferences about them because of the low number of informants who identified them.

Table 11

Summary of Characteristics Ranked 3-13 out of 13

Leadership characteristic	Total informants	Chair	CEO	VP	Other	SRHA	SPH	Past	Present	Female	Male
3. Honest	6	1	3	1	1	2	4	4	2	5	1
4. Strong	6	1	2	2	1	1	5	4	2	5	1
5. Visible	4	1	2	1	0	2	2	2	2	3	1
6. Confidence	3	1	1	0	1	1	2	3	0	1	2
7. Courage	3	0	3	0	0	1	2	2	1	2	1
8. Innovative	3	1	2	0	0	0	3	1	2	2	1
9. Soulful	3	0	2	1	0	1	2	2	1	3	0
10. Tolerance	3	1	1	1	0	3	0	2	1	2	1
11. Creative	2	0	1	0	1	0	2	1	1	2	0
12. Passionate	2	0	1	1	0	1	1	0	2	2	0
13. Professional	2	2	0	0	0	1	1	2	0	1	1

3. Honest: Six informants identified honesty as essential to building relationships and dealing with conflict. Most spoke of being honest in terms of communication. One board chair referred to "a very honest way of dealing with tensions and disagreement when there is sort of mutual disagreements, that kind of thing." Another informant stated that the first step in building relationships is to have "dead honest and honourable discussions."

4. Strong: Six informants identified the need for a leader to be strong and to have strength of conviction. It is interesting to note that five of the informants were from SPH. One informant stated that "there was some strong leadership by some of the Grey Nuns at the time," which may explain why five of the eight informants from SPH mentioned this characteristic.

5. Visible: Four informants mentioned the leadership characteristic of visibility, which they also described as "being present." One CEO reported:

> I was a very visible CEO. We did regular town halls . . . . I believe very much that you need to be out and about and meeting both people in the organization and outside of your organization, and that is . . . how people accept your leadership to a degree.

6. Confidence: Three informants spoke of the need for leaders to be confident, which in turn impacts the confidence of followers in the decisions being made, even if they do not agree with the decisions. One informant saw having the board chairs' support as important: "(He/She) had confidence in me, so that was important . . . . Gosh, I can't stress enough how important it is that the board chair has confidence in the CEO." Another leader emphasized the need to

> have a sense of confidence in your partner. You have to be open in sharing information; you have to be transparent so the partner knows that in the back room you are not cookin' a deal to their disadvantage . . . and to your advantage.

7. Courage: Three informants identified courage and risk taking as values. One informant that that leaders have to think "outside the box, and they ha[ve] to value risk-taking and courage."

8. Innovative: Three informants, all of whom are SPH affiliates, identified innovation as a quality of a leader. One explained:

> Well, in my mind, to make this happen they had to value innovation. Well, first of all, they had to value working together. So the value of respect. They had to have a leap of faith, so the value of trust. They had to have—all of this evolved over time, but even to go into such different constructs . . . [means that] they had to value innovation. In other words, they had to have a willingness to do something different.

9. Soulful: Three informants used words such as *soulful*, *spiritual*, or *spirituality* and emphasized the importance of self-reflection. They spoke of leading with a "spiritual soulfulness, soulfulness, and reflection."

10. Tolerance: Three informants from SRHA cited tolerance an essential characteristic. With the implementation of the integration strategy, the leaders had to have tolerance for ambiguity and time for others to grasp change. One informant stated, "And so patience, tolerance" was necessary to implement the partnership agreement.

11. Creative: Two informants identified the need for a leader to be creative and to encourage creativity. One present informant talked about past leaders: "They basically were very creative, I think, deep creativity" and emphasized that creativity was required to integrate all of the clinical programs.

12. Passionate: The same CEO informant who referred to creativity also talked about passion and referred to specific individuals as having this characteristic, which he/she considered inspirational. One VP also spoke of the passion of one past leader: "(He/She) was a very passionate, very committed" person.

13. Professional: Two board chairs mentioned the professionalism of the leaders who were involved in the development and implementation of the strategy as a key characteristic. One informant stated that the leaders let go of personal goals and focused on community goals and that their professionalism may have been related to their educational preparation; this informant "recognized professional integrity."

Evidence of Values-Based Leadership

Four themes identified in the literature on values-based leadership were used in this second deductive step of coding. In this step the 39 behaviours and characteristics identified in step 1 were reviewed for fit into the four themes of vision, values, and mission; ethics and integrity; service and inspiration; and legacy. Of these 39 behaviours and characteristics, 31 were congruent with one or more of the four themes.

Vision, values, and mission. The summary of the literature review revealed that the vision, values, and mission of organizations are the norms and standards that form the culture of the organization and provide a sense of meaning and purpose. Leaders empower others, create meaning, think reflectively, and communicate clearly. The leadership behaviours and characteristic that fit this theme include communicating openly, living the mission, and being values driven, visionary, committed, clear, and passionate. Table 12 displays in descending order the leadership behaviour or characteristic, the corresponding number of informants who identified the attribute, and the literature that supported categorizing them as vision, values, and mission.

Table 12

Vision, Values, and Mission

Number of informants	Behaviour or characteristic	Literature review articles
15	Communicating openly	Bass & Steidlmeier, 1999; Cummings, Hayduk & Estabrooks, 2005; Dunham-Taylor, 2000; Gragnolati & Stupak, 2002; Gosling & Mintzberg, 2003; Pendleton & King, 2002; Perra, 2001; Schwartz & Tumblin, 2002; Shirey, 2005; Trofino, 1995; Valentino, 2004
11	Living the mission	Bass & Steidlmeier, 1999; Bennis, 1999; Gosling & Mintzberg, 2003; Gragnolati & Stupak, 2002; Pendleton & King, 2002; Schwartz & Tumblin, 2002; Shirey, 2005; Trofino, 1995; Valentino, 2004
8	Being values driven	Bass & Steidlmeier, 1999; Bennis, 1999; Bruhn, 2004a, 2004b; Dunham-Taylor, 2000; Gosling & Mintzberg, 2003; Gragnolati & Stupak, 2002; Howatson-Jones, 2004; Kuczmarski & Kuczmarski, 1995; Leatt & Porter, 2003; McEnroe, 1995; McNeese-Smith & Crook, 2003; O'Toole, 1995; Pendleton & King, 2002; Schwartz & Tumblin, 2002; Tourangeau & McGilton, 2004; Trofino, 1995; Upenieks, 2003; Valentino, 2004
8	Visionary	Bass & Steidlmeier, 1999; Bennis, 1999; Bruhn, 2004a; Dunham-Taylor, 2000; Gosling & Mintzberg, 2003; Gragnolati & Stupak, 2002; Pendleton & King, 2002; Perra, 2001; Schwartz & Tumblin, 2002; Strack & Fottler, 2002; Trofino, 1995; Valentino, 2004
8	Being committed	Bass & Steidlmeier, 1999; Gosling & Mintzberg, 2003; Gragnolati & Stupak, 2002; Pendleton & King, 2002; Trofino, 1995
4	Being clear	McNeese-Smith & Crook, 2003; Pendleton & King, 2002; Perra, 2001; Shirey, 2005; Valentino, 2004
2	Passionate	Bass & Steidlmeier, 1999; Bennis, 1999; Kuczmarski & Kuczmarski, 1995; Upenieks, 2003

Ethics and integrity. The summary of the literature review described integrity as the actions and decisions based on ethical and caring behaviours. Ethical leaders do the right thing for the right reasons for the good of the organization and staff, and they foster a sense of trust and respect. The leadership behaviours and characteristics of communicating openly, trusting, treating fairly versus equality, doing right, being committed, being respectful, being honest, being strong, and being clear were categorized under the theme of ethics and integrity. Table 13 summarizes the number of informants, the behaviour or characteristic that they identified, and the literature that supported categorizing them as ethics and integrity.

Service and inspiration. According to the literature reviewed, inspiration comes from a place of abundance, love, and service. Service is what leaders do for the staff, organization, and community. They help the staff to see what is in it for them. Leaders inspire people through encouragement and commitment based on relationship. The leadership behaviours and characteristics of communicating openly, acting collaboratively, serving the community, using power, acting as a steward, being committed, pursuing personal growth, having an individual focus, being accountable, being conscious, being visible, giving support, being soulful, and solving problems are categorized under this theme. Table 14 summarizes the number of informants, the behaviour or characteristic that they identified, and the literature that supported categorizing them as service and inspiration.

Table 13

Ethics and Integrity

Number of informants	Behaviour or characteristic	Literature review articles
15	Openly communicating	Bass & Steidlmeier, 1999; Cummings, Hayduk & Estabrooks, 2005; Dunham-Taylor, 2000; Gosling & Mintzberg, 2003; Gragnolati & Stupak, 2002; Pendleton & King, 2002; Perra, 2001; Schwartz & Tumblin, 2002; Shirey, 2005; Trofino, 1995; Upenieks, 2003; Valentino, 2004; Vitello-Cicciu, 2002
12	Being trusting	Bennis, 1999; Pendleton & King, 2002; Perra, 2001; Valentino, 2004, Vitello-Cicciu, 2002
11	Treating fairly vs. equally	Bruhn, 2004a; Shirey, 2005; Vitello-Cicciu, 2002
11	Doing right	Bass & Steidlmeier, 1999; Bruhn, 2004b; Collins, 2001; Kuczmarski & Kuczmarski, 1995; O'Toole, 1995; Schwartz & Tumblin, 2002; Shirey, 2005; Vitello-Cicciu, 2002
8	Being committed	Bass & Steidlmeier, 1999; Gosling & Mintzberg, 2003; Gragnolati & Stupak, 2002; Pendleton & King, 2002; Trofino, 1995
8	Being respectful	Howatson-Jones, 2004; Pendleton & King, 2002; Perra, 2001; Vitello-Cicciu, 2002;
6	Honest	Bruhn, 2004b; Perra, 2001; Shirey, 2005; Upenieks, 2003
6	Strong	Perra, 2001; Schwartz & Tumblin, 2002
4	Being clear	McNeese-Smith & Crook, 2003; Pendleton & King, 2002; Perra, 2001; Shirey, 2005; Valentino, 2004

Table 14

Service and Inspiration

Number of informants	Behaviour or characteristic	Literature review articles
15	Communicating openly	Bass & Steidlmeier, 1999; Cummings, Hayduk, & Estabrooks, 2005; Dunham-Taylor, 2000; Gragnolati & Stupak, 2002; Gosling & Mintzberg, 2003; Pendleton & King, 2002; Perra, 2001; Schwartz & Tumblin, 2002; Shirey, 2005; Trofino, 1995; Valentino, 2004; Vitello-Cicciu, 2002
15	Acting collaboratively	Howatson-Jones, 2004; McEnroe, 1995; Vitello-Cicciu, 2002; Upenieks, 2003
13	Serving the community	Howatson-Jones, 2004; McEnroe, 1995; McNeese-Smith & Crook, 2003; Schwartz & Tumblin, 2002; Secretan, 2004
13	Using power	Dunham-Taylor, 2000; Perra, 2001; Schwartz & Tumblin, 2002; Vitello-Cicciu, 2002
11	Acting as a steward	Collins, 2001; Gosling & Mintzberg, 2003; Leatt & Porter, 2003
8	Being committed	Bass & Steidlmeier, 1999; Gosling & Mintzberg, 2003; Gragnolati & Stupak, 2002; Pendleton & King, 2002; Trofino, 1995
5	Pursuing personal growth	Bass & Steidlmeier, 1999; Gosling & Mintzberg, 2003; Howatson-Jones, 2004; Kuczmarski & Kuczmarski, 1995; Leatt & Porter, 2003; Perra, 2001; Schwartz & Tumblin, 2002; Vitello-Cicciu, 2002
5	Having an individual focus	Bass & Steidlmeier, 1999; Collins, 2001; McNeese-Smith & Crook, 2003; Perra, 2001; Schwartz & Tumblin, 2002; Shirey, 2005; Vitello-Cicciu, 2002
4	Being accountable	Bruhn, 2004b; Vitello-Cicciu, 2002
4	Being conscious	Howatson-Jones, 2004; Kuczmarski & Kuczmarski, 1995; Leatt & Porter, 2003
4	Being visible	Gosling & Mintzberg, 2003; Upenieks, 2003
4	Giving support	Cummings, Hayduk, & Estabrooks, 2005; McNeese-Smith & Crook, 2003; Pendleton & King, 2002; Upenieks, 2003
3	Soulful	Howatson-Jones, 2004; Kuczmarski & Kuczmarski, 1995; Leatt & Porter, 2003
2	Solving problems	Gosling & Mintzberg, 2003; Perra, 2001

Legacy. The summary of the literature review stated that leaders ensure that their organization's culture remains intact and continues to be reinforced even after people leave. They also ensure that core values are woven into the social fabric or culture of the organization so that they will endure long after the leader has gone. The leadership behaviours and characteristics of communicating openly, maintaining sustainability, living with change, acting with political awareness, building teams, being innovative, being creative, and acting professionally fit into the legacy category. Table 15 summarizes the number of informants, the behaviour or characteristic that the informants identified, and the literature that supported categorizing them as legacy.

Findings From Inductive Analysis

In the final level of coding, an inductive approach was used to examine the leadership behaviours and characteristics that the respondents identified that were not directly congruent with the four themes identified in the literature on values-based leadership. Seven additional behaviours and characteristics were identified through the process. Four leadership characteristics were identified in the inductive analysis. These were patience, courage, tolerance and confidence. The three leadership behaviours identified were taking opportunities, resolving conflict, and being evolutionary. These are summarized in Table 16 in order of most to least frequency mentioned.

Chapter Summary

Two sources of data were analyzed: documents and interviews. Thirteen documents were analyzed to identify contextual and chronological factors and validate comments from the interview and are reported on in this chapter. Fifteen semistructured interviews were conducted. The interviews were analyzed using a two-step deductive

Table 15

Legacy

Number of informants	Behaviour or characteristic	Literature review articles
15	Communicating openly	Bass & Steidlmeier, 1999; Cummings, Hayduk & Estabrooks, 2005; Dunham-Taylor, 2000; Gosling & Mintzberg, 2003; Gragnolati & Stupak, 2002; Pendleton & King, 2002; Perra, 2001; Schwartz & Tumblin, 2002; Shirey, 2005; Trofino, 1995; Valentino, 2004
14	Maintaining sustainability	Collins, 2001; Leatt & Porter, 2003
13	Living with change	Bruhn, 2004b; Gosling & Mintzberg, 2003; Perra, 2001; Valentino, 2004
10	Acting with political awareness	Gosling & Mintzberg, 2003; Vitello-Cicciu, 2002
6	Building teams	Dunham-Taylor, 2000
3	Innovative	Pendleton & King (2002); Vitello-Cicciu, 2002
2	Creative	Pendleton & King (2002)
2	Professional	Collins, 2001; Perra, 2001

Table 16

The Leftovers

Number of informants	Behaviour or characteristic
10	Patience
5	Taking opportunities
3	Courage
3	Tolerance
3	Confidence
3	Resolving conflict
2	Being evolutionary

coding approach and a final inductive coding approach. The 15 informants identified 39 leadership behaviours and characteristics of past and present leaders who were involved in the development, implementation, and continuation of a major change initiative. Thirty-one of the identified behaviour and characteristics were directly congruent with the four themes derived from the literature on values-based leadership. Seven additional behaviours and characteristics were identified through an inductive analysis. These findings are discussed in more detail in the following chapter.

CHAPTER FIVE:

DISCUSSION OF THE FINDINGS

As previously stated, the interviews conducted for the LINCS program were designed to identify contextual factors and leadership approaches related to an administrative integration strategy developed and implemented in the Saskatoon Health Region. The values and substance of this integration strategy were summarized in a document entitled St. Paul's Hospital and Saskatoon District Health Joint Service Management Partnership (1996). The original partnership agreement was signed in 1996 and renegotiated in 2005. The research conducted for this thesis was a secondary analysis of the interview transcripts designed to answer the following two questions:

1. What are the leadership characteristics, behaviours, and values of the past and present healthcare leaders in Saskatoon who developed, implemented, and maintained the partnership agreement between St. Paul's Hospital and Saskatoon Regional Health Authority?
2. Do these characteristics, behaviours, and values suggest a leadership style?

Discussion of the Contextual Factors

Several authors (Antrobus & Kitson, 1999; Avolio, 2007; Lord, Brown, Harvey, & Hall, 2001; Wong & Cummings, 2007) have criticized the contemporary literature on leadership as being univariate, focusing on the leader's behaviour, or bivariate, by focusing on the leader's behaviour and the followers' perceptions, but neglecting the contextual factors. Avolio stated that "the majority of leadership theories are context free" (p. 25). Antrobus and Kitson described the previously unreported phenomenon of the impact of health policy on nursing leadership and vice versa. Wong and Cummings recognized that healthcare organizations are complex and that leadership and patient outcomes have to be understood in the context of the climate and culture of the organization (p. 519).

Documents provided by the research team and informants were analyzed to identify contextual factors which informed our understanding and the interpretation of the interview data. A number of contextual factors were identified from analysis of 13 documents and questions in the interview guide. In this study, an understanding of context is a critical response to the interpretation of informants' responses.

Lord et al.. (2001) designed a prototype model that illustrates the interconnectedness of constructs such as society and organization culture, group identities, tasks, and gender. These authors concluded that leaders "focused on the environment are more likely to be successful as leaders than individuals who are insensitive to their external environments" (p. 332). Avolio (2007) identified context as an important moderator of leadership behaviour and identified three different but connected contexts: (a) The historical context is the climate prior to the emergence of the leader, (b) the proximal context is the current work climate and the characteristics of the group and tasks, and (c) the distal context is the organizational culture and external environment. The organizational culture also includes staff's perceptions with "regard to the organization's fundamental properties (policy, procedures and practices)" (p. 29). Avolio's conceptualization of the context provides a useful framework for the discussion of the contextual factors in Saskatoon describing the 10-year period of the original partnership agreement.

The Historical Context

The historical context created impetus for development of the partnership agreement. The government mandated regionalization and created regional health authorities as a mechanism to implement this policy. In turn, the regional health authorities signed affiliation agreements to form contractual relationships between them and the privately owned and voluntary organizations. The newly formed regional health authority was responsible for efficiency, the elimination of duplications, sustainability, and budget cuts within Saskatoon. Closing SPH was a strategy that the board considered; however, this created political unrest in the Catholic and local community that SPH serves. The political repercussions for SRHA and the survival of SPH created a conducive environment for both organizations to consider working together. Prior to these changes, the relationship between the two organizations was competitive and lacked trust. All respondents identified the need to move from a competitive environment to one of collaboration to consolidate acute care services and meet the needs of the community. SPH and SRHA wanted a more collaborative relationship, and thus they conceptualized and implemented the partnership agreement (described in chapter one).

The Proximal Context

As regionalization was implemented in Saskatoon, a number of structural changes occurred that effected employees, work climate and tasks. The implementation of the partnership agreement and the new integrated structure required the elimination of duplicated positions; therefore, employees from both organizations had to reapply for their jobs. This turmoil did not impact those in middle manager and frontline positions. Both CEOs and the medical chief of staff were involved in the interview and selection process. The amalgamation of specialty clinical services in specific hospitals maintained a critical mass of staff and educational requirements. Decisions were based on clear criteria, with an emphasis on what was right for the community. The informants identified this as critical during this turbulent time. The integration of clinical service was based on a model of collaboration, yet until this time the relationship between the organizations had been tense and uncomfortable; the leaders had had to commit to the values and vision of the partnership agreement for this change to be successful.

Another proximal contextual factor was the structural changes that were required in health service groups to organize and create the main framework for the integrated model of care, which outlined which organization had responsibilities and accountabilities for the care groups (Appendix E). A foundational structure for the partnership agreement was the formation of a Shared Service Committee at which the executive of both boards and both CEOs helped with decisions or conflict resolution. See Appendix B for the ethical framework used for decision making. This document outlines how the relationship would proceed and the values that guided it.

Nonclinical services such as Foods Services, Diagnostics, Human Resources, and Finance also became integrated programs. Although Human Resources was an SRHA-managed group, SPH-based managers and frontline staff remained SPH employees, which was critical for SPH's staff to be orientated and committed to its values and mission. SRHA managed the finance department, and the VP of Finance attended the board meetings of both SRHA and SPH.

The process of change included determining which organization would manage which programs and how to integrate the medical staff. It was important that SPH have responsibility for some of the larger care services for this model to work. SPH's giving up of financial control to SRHA was a significant concession, and all respondents considered it key to the integration of services. The processes for creating the new structure were open and transparent, which the interview informants identified as crucial to building trust, and they considered the processes fair. Thirteen of the informants talked about power, and they all referred to influence rather than control. They felt that someone who needed control could not survive in that environment. Argyris (1998) and Huey (1994) warned that relinquishing control is hard for senior executives to do.

One of the first processes to be implemented was the joint leadership meeting between SPH and SRHA senior executive teams; at the same time, joint board meetings were also being held. Eventually, a shared governance committee was created that consisted of both CEOs and both board Executive Committee members. During the entire process the emphasis was on the importance of relationship and communication.

The Distal Context

Documentary evidence and interview data provided insight into the importance of and effects of the distal context which includes the organizational culture and external environment. The development, implementation, and maintenance of the partnership agreement was a direct result of the behaviours and characteristics of the healthcare and community leaders in Saskatoon. Eight informants identified the need for leaders to be committed to the partnership agreement to sustain it. They acknowledged that many outsiders, including political leaders, were still sceptical about its long-term success. Of note, there have been six different CEOs in the 10-year span, and yet the partnership agreement has survived. The leaders in Saskatoon hired people who were a good fit for the organization and who were committed to the model, thus ensuring its sustainability. One board chair informant stated that when a new CEO was recruited, the candidates were asked if they knew about the partnership agreement and what their thoughts were on the agreement. This informant recalled that one candidate, who had excellent credentials, considered it "unworkable, completely. It's got to go." That candidate was not hired as a CEO in Saskatoon because he/she did not believe in the partnership agreement.

Discussion of Leaders' Behaviours and Characteristics

The first level of deductive coding resulted in the identification of 26 leadership behaviours and 13 leadership characteristics. In chapter four, these were presented in Tables 7 through 11 in the separate categories of behaviours and characteristics in order of frequency. When behaviours and characteristics are examined together in their order of frequency, a strong action orientation is evident. This is illustrated in Figure 1 below. In this figure, behaviours and characteristics were combined to illustrate relative prominence in the responses of informants. Reading from left to right, the number of informants who mentioned each item is shown in brackets. Most frequently mentioned items appear in the upper two lines of the figure, and all of these are behaviours. Characteristics are shown in uppercase bold type, and were mentioned less frequently. Two leadership behaviours were mentioned by all informants, *acting collaboratively* and *communicating openly*. In the search for congruence and differences in the number of respondents according to characteristics of corporation, timing and position, the following trends emerged.

Acting collaboratively (15)	Communicating openly (15)	Maintaining sustainability (14)	Living with change (13)	Using power (13)
Serving the community (13)	Trusting (12)	Treating fairly vs. equally (11)	Living the mission (11)	Doing right (11)
Acting as a steward (11)	Acting with political awareness (10)	**PATIENCE** (10)	Being committed (8)	Being respectful (8)
Being values driven (8)	**VISIONARY** (8)	Building teams (6)	**HONEST** (6)	**STRONG** (6)
Pursing personal growth (5)	Having an individual focus (5)	Taking opportunities (5)	Being accountable (4)	Being clear (4)
Being conscious (4)	Giving support (4)	**VISIBLE** (4)	**CONFIDENCE** (3)	**COURAGE** (3)
INNOVATIVE (3)	Resolving conflict (3)	**SOULFUL** (3)	**TOLERANCE** (3)	Being evolutionary (2)
CREATIVE (2)	**PASSIONATE** (2)	**PROFESSIONAL** (2)	Solving problems (2)	

Figure 1. All behaviours and characteristics.

Analysis of Responses by Corporation

A comparison of the informants' responses according to corporation revealed congruency between the most frequently identified leadership behaviours and characteristics. Although the numbers were small, a comparison of the responses between SPH and SRHA informants demonstrates some interesting differences. Informants from SPH emphasized the behaviours of serving the community, accepting accountability, acting as a steward, giving support, and living the mission. More SRHA than SPH informants spoke of being committed, being respectful, and tolerant. Commitment and respect were required from both organizations, but unless SHRA saw the partnership as adding value, there was no reason for it to remain in the integrated model.

Differences in Perception of Past and Present Informants

The majority of informants agreed on the top behaviours and characteristics. However, some patterns emerged when the responses of the informants from the past were compared to informants in the present. Past informants mentioned patience, fairness, stewardship, doing right, political awareness, and being values driven more frequently than the present leaders who identified being conscious and committed more often than the past leaders. These findings are summarized in Table 17 and are probably indicative of the political climate at the time. As the partnership model was being implemented there was a need to eliminate duplicate positions and to move services. In this context the behaviours and characteristics of patience, fairness, and doing right have particular relevance. Stewardship and acting with political awareness were required in the overall context. Past SPH informants placed particular emphasis on being values driven during this time. In the current climate, commitment to maintaining the partnership required that all leaders in the organization are conscious of which organization and CEO have the lead role for particular clinical services.

Congruence Between Board Chairs and Senior Leaders

When the data were examined according to each informant's position there was a striking congruence in the leadership behaviours and characteristics valued by board chairs, CEOs, and the senior leadership team, comprised of both CEOs and VPs. Three of the six CEOs had previously been VPs and several other informants were new VPs in the regional structure. Again, the attributes that were most valued were predominantly action orientated as illustrated in Table 18.

Table 17

Leadership Behaviours and Characteristics: Differences between Present and Past Leaders

Leadership behaviour or characteristic	Past	Present
Fairness versus equality	7	4
Doing right	7	4
Stewardship	7	4
Acting with political awareness	7	3
Patience	8	2
Being committed	3	5
Being values-driven	6	2
Being conscious	0	4

Table 18

Congruence Between Board Chairs and Senior Leaders

Attribute	Senior leaders (CEO +VP)	CEOs	Board chairs
Acting collaboratively	9/9	6/6	4/4
Communicating openly	9/9	6/6	4/4
Maintaining sustainability	8/9	5/6	4/4
Living with change	7/9	6/6	4/4
Using power	8/9	6/6	4/4
Serving the community	8/9	6/6	4/4
Trusting	8/9	5/6	4/4
Fairness	7/9	5/6	
Living the mission	8/9	6/6	
Doing right	8/9	5/6	
Acting as a steward	6/9	5/6	3/4
Acting with political awareness	5/9	4/6	4/4
Being committed	7/9	4/6	
Being respectful	5/9	4/6	
Being values driven	5/9	4/6	

The finding of congruence in the values of the board and the senior leadership team is important. Had there been dissonance, the partnership agreement may not have survived. Both past and present boards of both corporations structured and managed the CEO selection process in a common and intentional way. CEO candidates were asked about their knowledge and views on the partnership agreement and candidates prepared to work within the common values of the two boards were selected.

Articulating the organization's mission and values is the role of the CEO and the senior leadership team, and followers expect them to act ethically and fairly. Behaviours and characteristics such as living with change, using power, maintaining sustainability, serving the community, acting as a steward, and acting with political awareness were foremost for the board chairs, illustrating their awareness of their governance role. All informants identified the leadership behaviour of collaboration. All stated that leaders within this integrated model of care would require a collaborative leadership style, and the concept of collaborative was repeatedly mentioned.

Collaboration

Successful collaboration requires more than an appropriate leadership style. Sullivan (1998) described collaboration as an open-system model or theory with four major components: process, partnership, practice, and outcomes. She defined interorganizational collaboration as a partnership with a common philosophy:

> Collaboration is defined as a dynamic transforming process of creating a power sharing partnership for pervasive application in health care practice, education, research, and organizational settings for the purposeful attention to needs and problems in order to achieve likely successful outcomes. (p. 6)

The 15 leadership behaviours identified by board chairs and senior leaders are reflected in the concepts of partnership and practice that appear in the literature on collaborative theory.

Sullivan (1998) identified forces of change that cause organizations to consider collaboration models. According to Mycek (2006), partnerships are usually created to achieve stability in the face of organizational change. Many of these organizations are faced with massive restructuring of the local health care system and funding sources. These situations that Mycek and Sullivan described are similar to the climate in Saskatoon at the time of the creation and implementation of the partnership agreement. In a different sociopolitical environment, it is unlikely that SRHA and SPH would have considered a partnership agreement when they did.

Interorganizational collaborations are particularly complex because of the human resource, financial, decision-making, and shared-power issues that have to be addressed. This was certainly the case for SRHA and SPH. The goal of most hospital collaborations is to improve access to and continuity of care (Wollf, 2001), which was the reason that SRHA and SPH entered into a partnership agreement. All documents that referred to the partnership agreement clearly stated that the reason for the agreement was to improve continuity of care, access, and efficiencies and to eliminate duplication.

Sullivan (1998) recommended the development of measurement outcomes to ensure organizational accountabilities in collaborative arrangements. She suggested that organization outcomes such as cost-effective care, patient satisfaction, job satisfaction, and improved staff retention could be expected to result directly from collaborative models of care (p. 123). Both Wollf (2001) and Sullivan recommended the creation of a framework to outline shared accountabilities and decision making. In the Saskatoon context, the *Decision Framework* document (Shared Services Committee, 1996) addressed this need. Mycek (2006) recognized that both boards have to buy in for interorganizational collaborations to succeed. Whereas CEOs cannot enter collaborative relationships without board support, an interorganizational collaboration requires skillful action by CEOs.

Communication and relationships built on trust, honesty, and respect are essential for collaboration to work (Mycek, 2006: Wollf, 2001). Successful collaborations result from leaders' ability to share power, resolve conflict constructively, communicate clearly, and build succession strategies. These behaviours and characteristics were mentioned by informants in Saskatoon. Sullivan (1998) stated that the success of this type of collaboration depends on clearly articulated mission, visions, and goals. In Saskatoon, the partnership agreement and the integrated regional structure required to implement it have been sustained over a ten year period. This fact suggests that board chairs and senior leaders were behaving in accordance with their stated values and also with each other as they designed and implemented their complex interorganizational relationships.

Axelsson and Axelsson (2006) warned of the barriers and challenges that any coalition faces if organizations maintain their own values rather than sharing values. Therefore, it is especially interesting that informants in this study stated that both SPH and SRHA have maintained their own corporate mission, vision, and values. The findings of this study challenge the conventional wisdom which suggests a need to dismantle pre-existing or unique corporate culture in order to achieve integration or collaboration. It may be that the shared values of the guiding principles and the ethical framework for decision making provided the support to overcome these barriers. Many of the leadership attributes reported in the literature on collaboration models are congruent with the leadership behaviours and characteristics that the informants from SRHA and SPH identified. Sullivan stated, “If the larger systems and collaborators are investing time and energy in taking first steps in developing the collaborative practice, then it is highly likely to be successful” (p. 120). The fact that the partnership agreement is still in effect lends validity to the informants’ reports on the leadership behaviours and characteristics.

Values-Based Leadership

According to Lemire Rodger (2006), leadership research is contradictory and sometimes trivial. Although there is a plethora of articles and books on leadership, journals dedicated to leadership, management and administration, and theories of leadership are still evolving. Because leadership in general is difficult to define, defining values-based leadership has proven to be particularly challenging. The underlying premise of values-based leadership is that it is a way of acting and making decisions based on stated values or principles (Preziosi, 1994; Reilly & Ehlinger, 2007). The main task of the leaders is to articulate these values, and followers then become leaders as they learn to act and behave according to consistent values (Preziosi, 1994). Reilly and Ehlinger cautioned that a change in leadership or organizational goals can challenge the ongoing commitment to the values. Collins and Porras (1996) suggested the opposite: that well-defined and articulated values are anchors in times of change and ensure that the organization continues to adapt. The findings from this study suggest that the philosophy of continuity of leadership and values have been important factors in the success of interorganizational collaboration in Saskatoon.

Of the 39 leadership behaviours and characteristics that the informants in this study identified, 31 were congruent with one or more of the four themes identified from the literature on values-based leadership. The four themes are vision, values, and mission; ethics and integrity; service and inspiration; and legacy. The values of the partnership agreement were affirmed in the original *St. Paul's Hospital–Saskatoon District Health joint service management partnership (1996)* and re-affirmed 10 years later in the *Partnership agreement between Saskatoon Regional Health Authority and St. Paul's Hospital (Grey Nuns) of Saskatoon.* (2005b). This fact corroborated the perceptions of the informants in the study. Although there have been changes in leadership as CEOs and board chairs have moved on, the foundational values have not changed. This suggests that the values have been well articulated and integrated into the culture of each corporation through the actions of leaders. In this study there was remarkable consistency and continuity in informants' description of the leadership behaviour, characteristics and values. Values-based leadership is not a leadership style; rather, it is a theme that appears in the literature and that is foundational to numerous leadership styles.

Leadership Style

This study was undertaken to explore whether the characteristics, behaviours, and values identified by leaders at SPH and SRHA suggested a leadership style defined as "the different combinations of tasks and relationship behaviours used to influence people to accomplish goals" (Huber et al., 2000, p. 254). The original LINCS research was undertaken to understand the conceptualization and operationalization of an administrative integration strategy outlined in the partnership agreement. Although the focus of the parent study was not on leadership styles, the interview data were rich with descriptions of leadership behaviours and characteristics and support this secondary analysis. All informants talked about the need for and presence of a collaborative leadership style. This is not a term that can be identified with theories and approaches commonly discussed in the leadership literature. Values-based leadership as discussed by the informants in this study could be viewed as an element of more than one theory of leadership. These include transformational leadership, authentic leadership, charismatic leadership, the five practices of leadership by Kouzes and Posner (2002), and servant leadership. These theories contain overlapping elements.

Avolio and Gardner (2005) envisioned authentic leadership as the root of all relational styles of leadership such as transformational, charismatic, and servant. According to Wong (2007), authentic leaders "influence via their strong sense of who they are and where they stand on issues, and values and beliefs" (p. 17). Kouzes and Posner described a type of transformational leadership (Pielstick, 1998; Wong, 2007) but did not link leadership behaviours to outcomes. Pielstick, in a meta-ethnographic analysis of the leadership literature on transforming leaders, reviewed the literature on transformational leadership, charismatic leadership, the five practices of leadership discussed by Kouzes and Posner, and servant leadership in a search for patterns and connections that describe transformational leadership (p. 16). He derived seven major themes: creating a shared vision, communicating the vision, building relationships, developing a supporting organizational culture, guiding implementation, exhibiting character, and achieving results. It is informative to consider the findings of this study in the context of the meta-ethnographic analysis on "transforming leaders" completed by Pielstick.

The first theme, creating a shared vision, is derived from shared needs, values, beliefs, and purposes. Pielstick (1998) stated that the shared vision of transforming leaders provides direction for organizational change and adaptation. Transformational leadership is an approach that is conducive to major change, development, initiative, and creativity in turbulent and uncertain environments (Bass & Avolio, 1994; Bass & Steidlmeier, 1999), such as that in Saskatoon in the early 1990s when the partnership agreement was conceptualized, developed, and implemented.

The second theme is communicating the vision. The ability to engage followers in discussion about a shared vision, values, and beliefs builds the culture of the organization. Transforming leaders act consistently and in accordance with the vision, values, and beliefs of the organization to build trust (Pielstick, 1998). As confirmed by this study, SRHA and SPH have been successful in articulating the guiding principles and ethical framework that support the partnership agreement. The informants in this study identified the behaviours of living the mission, being values driven, being visionary, using power, and doing right. All of the leaders articulated the values of collaboration and communication and spoke knowledgably about the partnership agreement.

The third theme is building relationships that are interactive, collaborative, and collegial. Transformational leaders motivate followers to view their work from new perspectives and develop skills and abilities, and they encourage them to look beyond their own interests (Bass & Avolio, 1994; Bass & Steidlmeier, 1999). Thirteen informants spoke about the need to be responsive to the community, which includes the general public, staff, and colleagues. They valued teamwork, a focus on the individual, visionary leadership, respect, and living the mission. These behaviours and characteristics are motivational for followers.

The fourth theme is developing a supportive organizational culture, which comprises the shared values and beliefs of the organization, Pielstick (1998) explained that culture is built through storytelling, myths, and participation in rituals and ceremonies. The informants discussed organizational culture in the context of the partnership agreement and the sociopolitical climate at the time of the creation and implementation of the partnership agreement. Several informants spoke of the rituals and ceremonies that were part of SPH. Fewer informants spoke about the culture of SRHA which is a much younger corporate entity. This also reflects SPH's emphasis on ensuring that its mission survives into the future and its recognition that this is facilitated through rituals and ceremonies.

The fifth theme is guiding implementation, which Pielstick (1998) stated includes the use of moral reasoning and principled judgments. The leader guides through a strategic process that reflects the organization's values, vision, and mission. Transforming leaders encourage calculated risk taking and innovating. According to Bass and Avolio (1994), transformational leaders encourage their followers to pursue intellectual and personal growth. They also encourage creativity, innovation, problem solving, and risk taking. The informants from SPH and SRHA identified the behaviours and characteristics of personal growth, creativity, innovation, and problem solving. In addition, they discussed the strategies and processes that took several years to implement and explained how the partnership agreement was used to guide this change.

The sixth theme is exhibiting character. Transforming leaders are principle centered and act with honesty, integrity, and trust. According to Pielstick (1998), transforming leaders are guided by the principles of justice, equity, dignity, and respect for every individual. Pielstick described the concept of power and clarified how transformational leaders use power to empower others; by doing so, they relinquish control. They promote organizational renewal and critical, creative, and reflective thinking. They are equally comfortable with political, cultural, and technical functions inside and outside the organization. Transformational leaders understand the organizational history, cultural sensitivity, and global issues. Some of the informants described the leaders in SRHA and SPH as having tolerance for ambiguity and uncertainty. The majority of the informants spoke of ethical behaviour or doing right. They also identified honesty and trust as important attributes of leaders who work in a collaborative model such as the partnership agreement.

The seventh theme is achieving results. Transforming leaders encourage commitment, self-sacrifice, motivation, and performance from followers (Pielstick, 1998), and they treat people with respect, dignity, fairness, justice, honesty, integrity, and equality. Transformational leaders act with integrity and have high ethical standards. They share power and look to influence rather than control. Thirteen and 11 informants, respectively, identified the behaviours of using power and doing right, and they talked of power in terms of influence rather than control. Informants in this study emphasized the need for a strong ethical framework, and some suggested that this was as a result of the relationship and having SPH at the table.

Conclusion

In this chapter the historical, proximal, and distal contexts for interorganizational collaboration between SPH and SRHA were addressed using information from documents and interviews. The context is significant because it provided the drive and the reason for SRHA and SPH to consider a partnership agreement.

Leadership behaviours and characteristics that the informants identified in the interviews were presented. An important finding is the congruence between past and present board chairs and the senior leadership team. If there had been dissonance, it is doubtful that the partnership agreement would still exist today, but both groups strove to ensure that time, energy, and resources were dedicated to ensuring that the partnership continues.

The underlying theme for this thesis was the determination of whether it would be possible to describe the values-based leadership and its presence in Saskatoon that some leaders suggested. The literature on values-based leadership confirms the leadership behaviours and characteristics that the informants identified. Thirty-one of the 39 identified behaviours and characteristics fit into one or more of the themes of vision, values, and mission; integrity and ethics; service and inspiration; and legacy.

Collaboration was discussed as a separate concept that all of the informants recognized. The partnership agreement is a collaborative model of care delivery. Collaboration is a construct with complex components that include process, partnership, practice, and outcomes.

Finally, the literature suggested that the behaviours and characteristics that the informants identified do not inform one leadership style. More in-depth interviews with the use of valid measurement tools would be required to link the findings to a leadership style. The research findings were discussed using Pielstick's (1998) seven themes in a meta-ethnographic analysis of the literature on transforming leadership.

In the following chapter the conclusion, limitations, and recommendations are presented.

CHAPTER SIX:

CONCLUSION AND RECOMMENDATIONS

Hibberd, Smith, and Wylie (2006) concluded that most research in nursing leadership is descriptive, has a small sample size, and therefore cannot be generalized; however, these studies do add to the body of knowledge. Nursing leaders have a primary responsibility for energizing and promoting change in a positive direction and supporting staff during the change. These "soft" skills of leadership behaviours and characteristics are components of organizational life and are not easily quantified, measured, or understood. Until the field of leadership research is more mature, descriptive studies will continue to inform it.

The purpose of this study was to explore themes that operationally define values-based leadership. To this end, a secondary analysis of data from the LINCS research program was undertaken. In this secondary analysis, the goal was to determine if it was possible to describe values-based leadership and its influence on health services in Saskatoon, as some leaders had suggested when interviewed for the LINCS study.

The original LINCS research was designed to understand the conceptualization and operationalization of an administrative integration strategy implemented in the regional health system of Saskatoon, Saskatchewan. A formal partnership agreement between two independent corporate entities SRHA and SPH, was created in 1995 as a way of implementing provincial health care policy to regionalize services and reduce costs. Leaders in Saskatoon made the choice to implement necessary changes through a partnership agreement and an integrated program management model intended to improve continuity of care, access, and efficiencies and to eliminate duplication of services.

In order to describe the concept of values-based leadership, a primary analysis of 13 documents and a secondary analysis of 15 semistructured interview transcripts was completed. The guiding questions for this research were:

1. What are the leadership characteristics, behaviours, and values of the past and present healthcare leaders in Saskatoon who developed, implemented, and maintained a partnership agreement between St. Paul's Hospital and Saskatoon Regional Health Authority?
2. Do these characteristics, behaviours, and values suggest a leadership style?

Deductive analysis of the data was completed in 2 steps. In step 1, leadership behaviours and characteristics identified by informants were documented. In step 2, four themes identified in the literature on values-based leadership were used to categorize informants' responses. These themes were vision, values and mission, ethics and integrity, service and inspiration and legacy. A third and final step in the analysis involved an inductive approach to the identification of additional themes.

Based on informants' responses it was possible to operationally define values-based leadership. Analysis of documents confirmed that there had been many structural and process changes during the 10 year time period examined in the study.

The Context

There was a highly charged political environment at the time the partnership agreement was created and implemented. Informants described the environment as turbulent and competitive. Implementation of the partnership agreement was driven by the need to increase efficiency and eliminate duplication as financial resources were constrained. All respondents identified the need to move from a competitive environment to one of collaboration in order to consolidate acute care services to meet the needs of the community. Implementing the partnership agreement required many structural and process changes for both corporations. The structural changes included amalgamation and transfer of clinical services, and elimination of duplicate positions. Interview informants described the processes for creating the new structure as being open, transparent and fair. This in turn, was identified as crucial to building trust.

Action Orientation

Analysis of interview data revealed a total of 39 leadership attributes identified by informants: 26 were defined as behaviours and 13 as characteristics. The top 15 attributes identified by senior leaders and board chairs, included acting collaboratively, communicating openly, maintaining sustainability, living with change, using power, serving the community, trusting, fairness, living the mission, doing right, acting as a steward, acting with political awareness, being committed, being respectful, and being values driven. The top 12 leadership attributes identified by respondents were behaviours. All of the identified leadership behaviours and characteristics are described in detail in chapter 4. When behaviours and characteristics are examined in their order of frequency, a strong action orientation on the part of the interview informants was evident.

Congruence and Continuity

There was remarkable congruence in informants' descriptions of the leadership behaviour, characteristics and values. Congruence was a key feature of the responses and perceptions of all informants. During the 10 year period examined in this study, there were changes in leadership in Saskatoon as CEOs and board chairs completed their terms and moved on. Never the less, all respondents referred to the foundational values and emphasized that they have remained constant. This suggests that the values have been well articulated and integrated into the culture of each of the two corporations through the actions of leaders. The findings from this study suggest that continuity of shared values and not individual or corporate philosophies has been an important factor in the success of interorganizational collaboration in Saskatoon.

The values of the different leader informants are congruent, and this has continued over time All informants spoke of the need for leaders to act collaboratively and communicate openly. The culture, values-based leadership style, and collaboration do not depend on any one individual or group. The well-defined and articulated values have served as anchors during continuous change, ensuring the achievement of necessary outcomes and , in this case, continuation of the partnership.

Thirteen informants talked about using power and suggested that someone who needs control could not survive in this environment. They emphasized that the partnership agreement is based on influence rather than control. In fact, the leaders in Saskatoon have intentionally hired people who are a good fit for the organization and who are committed to the model, thus ensuring its sustainability. Had there been dissonance, the partnership agreement may not have survived. Leaders in both corporations strive to ensure that time, energy, and resources are dedicated to ensuring that the partnership continues.

Collaboration as Behaviour and Process

All informants identified the importance of the leadership behaviour of collaboration, mentioning it repeatedly. They stated that leaders within the integrated regional management structure must have care required a collaborative leadership style. The 15 leadership behaviours identified by board chairs and senior leaders are reflected in the concepts of partnership and practice that appear in the literature on collaborative theory.

Many of the leadership attributes reported in the literature on collaboration models are congruent with the leadership behaviours and characteristics that the informants from SRHA and SPH identified. Therefore, it is especially interesting that informants in this study stated that both SPH and SRHA have maintained their own corporate mission, vision, and values. The findings of this study challenge the conventional wisdom which suggests a need to dismantle pre-existing or unique corporate culture in order to achieve integration or collaboration. It may be that the shared values of the guiding principles and the ethical framework for decision making have provided the support to overcome these barriers.

Values-Based Leadership

The literature on values-based leadership emphasized a need for synchronicity between the leader's and the organization's values. The hallmark of values-based leadership is communicating the vision and values of the organization and acting in congruence with these values. Shared, affirmed values make for healthy work environments; hence the importance of values-based leadership.

The underlying premise of values-based leadership is that it is a way of acting and making decisions based on stated values or principles. The main task of the leaders is to articulate these values, and followers then become leaders as they learn to act and behave according to consistent value. Four recurring themes were identified from the literature on the topic of values-based leadership: vision, values, and mission; ethics and integrity; service and inspiration; and legacy. Thirty-one of the 39 leadership behaviours and characteristics identified by informants in this study were congruent with one or more of the four themes. The success of this partnership agreement was related to the values-based leadership qualities of the leaders involved in the development and implementation of the partnership agreement. Informants perceived that these qualities have become an integral part of the leadership culture in SRHA and SPH, which continues to ensure the ongoing success of the partnership to this day.

Transforming Leadership Style

Seven leadership behaviours and characteristics that did not conform to the four themes identified in the literature on values-based leadership were examined for a link to other leadership theme. The attributes of resolving conflict, confidence, courage, patience, and tolerance were leadership traits that would be of benefit when leaders face a highly charged political situation or conflict and were labelled preparing for or dealing with adversity. Analysis of documents confirmed that healthcare climate before the implementation of the partnership agreement was considered competitive and adversarial. This finding is supported as the majority of the informants who identified these behaviours and characteristics were past leaders.

From an examination of the findings in this study it seems justified to conclude that values-based leadership is not a leadership style, but rather, a theme that appears in the literature about a number of leadership styles. Pielstick (1998) described a transforming leadership style in a meta-ethnographic analysis which included literature on transformational leadership, five practices of leadership by Kouzes and Posner, servant leadership and charismatic leadership. He identified seven themes, creating a shared vision, communicating the vision, building relationships, developing a supporting organizational culture, guiding implementation, exhibiting character, and achieving results. These 7 themes identified by Pielstick are similar to the 4 themes identified in the literature review on values-based leadership that was conducted at the outset of this study. The theme of vision, values and mission is similar to the themes of creating a shared vision and communicating the vision. The theme of ethics and integrity is similar to the themes of exhibiting character, and guiding implementation. The theme of service and inspiration is similar to the themes of building relationships and achieving results. The theme of legacy is similar to the theme of developing a supporting organizational culture. Based on the similarities between the themes of values-based leadership and transforming leaders, it is reasonable to conclude that the leaders in Saskatoon practice a transforming leadership style.

Collaboration as Outcome

According to Wheatley (1997), more than two thirds of organizational change efforts fail, and interorganizational change initiatives are particularly complex. The leaders in Saskatoon developed an unprecedented collaboration strategy to address the crisis of budget deficits, an aging workforce, crumbling capital infrastructures, high public expectations, increasing technological and pharmaceutical advances, the aging population, rising costs of care, and concerns about patient safety in their health region. In this context it is significant that in September 2005, 10 years after the original agreement was signed, the partnership agreement between the two organizations was reaffirmed and continues to be the framework for current health care decisions.

Informants in this study reported that benefits of this integrated approach have been better access, improved resource utilization, and a region wide interdisciplinary approach to health service planning, development, delivery, and quality monitoring. They perceived that each corporate entity had retained a unique identity and culture while achieving interdependence through a collaborative vision for health in the Saskatoon region. The partnership agreement is perceived by the informants in this study, to be successful because of the focus on those who are served.

Limitations

A secondary analysis relies on information that is collected to answer the research questions of the parent study. Although it would have been interesting and worthwhile to ask the leaders to speak about their personal leadership styles, this did not occur because the leadership interviews were not focused in this way. Therefore in this study, values-based leadership is inferred form informants' descriptions of their colleagues' characteristics and behaviours.

The sample consisted of all past and present CEOs and four of the five board chairs in the 10 years spanning 1995 to 2005.There is some potential for bias because the incomplete sample of executive informants was incomplete. As stated earlier, the sample of informants interviewed for the study included five individuals who were selected, not by position, but by recommendation of the primary informant. It is not known whether other informants in this category (VPs, GMs, etc.) would have similar knowledge or perceptions of the process and leaders who developed and implemented of the partnership agreement. No staff member below the GM level was interviewed, so it is not possible to determine from this study whether values-based leadership is perceived by staff who are closer to the frontline of the organization.

The informants in this study had all survived the downsizing and were successful in retaining positions. It would have been illuminating to interview a senior executive who did not survive the cutbacks. The informants spoke only of the job losses at the GM level and above and the perceptions of frontline staff were not obtained.

A deductive approach to the coding of interview data was adopted to lend objectivity to the analysis. Documents were used to verify information from the interviews and inductive content analysis was used to identify themes that did not arise form the literature on values-based leadership. Because there is limited literature on values-based leadership, this may have prescribed limits and/or particular emphasis in the identification of the themes used for deductive coding.

It is not possible to generalize from the study because of the small sample size.

Contributions of the Study

Marion and Uhl-Bien (2001) explained that "complexity science broadens conceptualizations of leadership from perspectives that are heavily invested in psychology and social psychology to include processes for managing dynamic systems interconnectivity" (p. 389). Healthcare organizations are complex, dynamic, and socially interconnected structures. Several aspects of this study enabled this complexity to be revealed.

It can be difficult for researchers, and especially novice researchers, to obtain access to board members, CEOs and executive level managers. In this study, there was a unique opportunity to conduct interviews with 15 senior individuals.

The longitudinal aspect of the study is also noteworthy. The time period of 10 years during which the partnership agreement was developed and sustained is significant when considered in the broader context of change implementation and interorganizational changes in particular. The 15 informants interviewed for this study held their positions at different times during this period. Thus while the findings of the study cannot be generalized to other leaders and settings, a strong argument can be made for the credibility of the findings in the Saskatoon health system context.

In this study, informants conceptualized collaboration as a leadership behaviour and as an ongoing process. The perceptions of congruence and continuity as reported by interview informants are reinforced by the fact that the collaboration was sustained and renewed by other leaders at the end of the ten year period from 1996 to 2005. The analysis of documents confirmed the turbulent and complex nature nature of the policy environment during this period, lending support for the perceptions of informants that commitment to shared values has been a factor in sustaining the collaboration in the face of continuing organization-specific cultures.

The successful interorganizational collaboration between SPH AND SRHA can also be viewed as a significant outcome of change design and implementation. Collaboration has been widely advocated but under researched. The findings of this study suggest that the values of leaders, as well as their behaviours and characteristics, should be studied in context, to develop a holistic understanding of how and why interorganizational collaborations and site-based change strategies succeed or fail. As suggested by Wheatly (1984) there is value in explicitly addressing issues such as trust, respect, shared values, beliefs, and other qualities which may influence or contribute to positive organizational outcomes such as the partnership examined in this study.

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APPENDIX A:

PROGRAM LEADERS' INTERVIEW GUIDE

Preamble

As a leader of healthcare in Saskatoon during the mid 1990s we are asking you to help us gain an understanding of the development, implementation, evaluation, and current status of the Joint Service Management Partnership (partnership agreement) between the Saskatoon Health Region and St. Paul's Hospital. We believe this Agreement illustrates an interesting example of inter-organization collaboration and decision making to integrate services.

You have had an opportunity to review the questions that will structure our interview today. The interview will take approximately 1 to 1.5 hours. It will be tape-recorded and I may take some notes while you are talking. This is to ensure that I understand what you have told me. Before we get started, do you have any questions?

Guiding Questions

1. Please help us clarify the partnership agreement integration strategy.
    - What is the partnership agreement between the Saskatoon Health Region and St. Paul's Hospital?
    - What do you feel are the key features of this Partnership.
2. What, if anything, is unique about this Partnership?

I would like to ask you about the planning and development stage:

3. Before the partnership agreement, what are your perceptions of the relationship between the Saskatoon Health Region and St. Paul's Hospital?
4. In your opinion how did various stakeholders view the relationship?
    - the community
    - health care providers,
    - administrators, and
    - Board members?
5. How was the need for this partnership agreement identified?
6. What factors were significant in gaining acceptance and approval for the partnership agreement?
    - How did inter-organization relationships evolve during the planning?

7. Were there particular external events that influenced the emergence of this partnership agreement?

8. Were there particular internal events that influenced the emergence of this partnership agreement?

9. Were there any individuals who were particularly important in helping to make this partnership agreement happen? What did these people do that made a difference?

10. From your point of view what were the key milestones or critical events in planning for the partnership agreement?

    - How did leadership characteristics and behaviours and values impact the planning of the agreement?

11. What was your role in the development of the agreement?

12. How would you describe the decision-making process which led to this partnership agreement.

    - How were decisions made?
    - Why was this one chosen?
    - Were other partnership models explored?

13. What issues arose in the decision making process?

    - How were these resolved?

14. What issues were most important to the Saskatoon Health Region; to St. Paul's Hospital?

Now I would like to ask you about how the Agreement was implemented:

15. What factors were significant in gaining acceptance and approval for the partnership agreement?

    - How did inter-organization relationships evolve during implementation?

16. What were the facilitators and barriers to implementation?

    - How was the agreement operationalized?

17. Were there particular external events that influenced the implementation of this partnership agreement?

18. Were there particular internal events that influenced the implementation of this partnership agreement?

19. Were there any individuals who were particularly important in helping to implement this partnership agreement? What did these people do that made a difference?

20. From your point of view what were the key milestones or critical events in implementing the partnership agreement?

21. How did leadership characteristics and behaviours and values impact the implementation of the agreement?

22. What was your role in the implementation of the agreement?

23. Did any unexpected events or relationships occur?

24. How has the partnership agreement affected the regional structure?

    - How is the Board structured?
    - Describe the organizational structure that resulted from the implementation.
    - Are there any financial implications for the Partnership? How are funds managed under the Agreement?

Now I would like to talk about evaluation and the current status of the Partnership:

25. How would you describe the relationships between the Saskatoon Health Region and St. Paul's Hospital today?

26. In your view what are the current issues?

    - How are these issues resolved?
    - What issues are most important to the Saskatoon Health Region and St. Paul's Hospital?

27. Has there been a need to adapt the partnership agreement along the way and why?

28. If adaptations were made to the partnership agreement, in your opinion, which were necessary? Which were not necessary?

29. Do you think that the partnership agreement has been fully implemented?

30. Have there been any formal evaluations of the strategy?

31. What are your perceptions of how the relationship between the Saskatoon Health Region and St. Paul's Hospital is currently viewed by stakeholders?
    - Community,
    - Health care providers,
    - Administrators, and
    - Board members?
32. How is the partnership agreement positioned within your regional structure?
    - Describe the organizational structure that resulted from the implementation.
    - How is the Board structured?
    - How is the medical staff structured?
33. What are some of the advantages with these organizational structures?
34. What are some of the challenges with these organizational structures?
35. What advice would you offer to other organization that might want to implement a similar partnership agreement?
36. What kind of values and leadership characteristics and behaviours do people need in order to work in this structure?
37. What do you see as the major outcomes of this structure?
38. Would you like to add any further information?

Thank you for your assistance.

APPENDIX B:

GUIDING PRINCIPLES OF THE PARTNERSHIP AGREEMENT AND ETHICAL FRAMEWORK AND THE GUIDING VALUES

Guiding Principles of the Partnership Agreement Between SRHA and SPH

1. The parties shall work interdependently towards the ongoing development of a common future direction

2. SPH shall continue to carry our its mission as a Christian institution in accordance with the Catholic faith. The moral code of the Catholic Church shall be acknowledged, respected and applied in all decisions affecting SPH.

3. The parties shall provide for the continuation of the mission and values of SPH through mission orientation and continuing education of all board members, staff, physicians and volunteers working at SPH.

4. The parties shall respect the existing cultures of each organization, and shall work towards a blending of these cultures in the best interests of the delivery of quality health services.

5. SPH shall appoint its own Chief Executive Officer who will be a member of SRHA senior leadership team.

6. The parties shall support and maintain an integrated senior leadership team which will guide both organizations in the planning and provision of quality health services.

7. Following development, the annual operating and capital budgets will be presented to the SPH Board for input and clarification and to the SRHA for approval. Funding allocated pursuant to the Funding Agreement will be used for the purposes of providing services. The parties acknowledge that all expenses and liabilities incurred in the context of the parties under this Agreement and the Funding Agreement are those of SRHA except expenses relating to those matters set forth in 2.1 (i) of this Agreement that SPH has agreed are solely its responsibilities.

8. SRHA will assume the accountability for surpluses and deficits that are incurred by SPH. SPH will demonstrate stewardship for the care groups/departments/services it governs and manages, with SRHA maintaining the final accountability in decisions regarding the allocation of dollars.

9. The parties shall ensure revenue generated by SPH, including without limitations, rentals, parking, hostel and funds for mission support provided to SPH through the St. Paul's Hospital Foundation shall be maintained and used by SPH for its purposes, including without limitations, in the areas of spiritual care, mission

services, volunteers services, clinical pastoral education, and administration and board support, all of which support the mission and culture of SPH.

10. Any expenditures relating to the acquisition of equipment for the purposes of clinical programs and services at SPH shall be made in accordance with identified regional needs and in accordance with regional approval processes.

11. The parties shall use their best efforts to ensure that health services are accessible to those in need, are offered within a continuum of care service delivery, and are delivered in a cost effective and efficient manner, in accordance with the applicable legislation of the Province of Saskatchewan.

12. The parties acknowledge that SP shall be responsible and accountable to SRHA for all performance expectations and accountability requirements established by Saskatchewan Health and are related to the care groups/departments/services governed by SPH. (SRHA & SPH, 2005b, p. 2)

Ethical Framework and the Guiding Values

What is the mission of the Shared Services Committee, of St. Paul's Hospital (SPH) and Saskatoon District Health (SDH)?

How do the congruencies of these missions impact this opportunity?

Core Values: Does the process AND the outcome, to the greatest extent possible, reflect the core values of both SDH and SPH?

Specifically, does the process AND outcome reflect:
  Respect for all,
  Foster Collaborative partnerships,
  Demonstrate compassionate caring,
  Display a holistic perspective,
  Demonstrate stewardship and accountability in the wise use of resources?
(Core Values: SPH)

AND

Does the process and outcome:
  Demonstrate Respect, Trust, Integrity, and Accountability?
  Foster a caring community?
  Demonstrate working together in a spirit of respect for democracy and diverse opinions, flexibility, a search for common ground and partnership?
  Focus on quality?
  Make responsible decisions?
  Create new futures together?
(Core values: SDH)

(Shared Services Committee, 1996, p. 1)

APPENDIX C:

INTERVIEW PACKAGE

INFORMATION LETTER FOR PARTICIPANTS

Phase I: Program Leaders Interview

Study Title: LINCS Research Program – Phase I		
Principal Investigator:	***Donna Lynn Smith*** RN, MEd, CPsych, CHE	(780) 492-9544
Co-Principal Investigator:	***Carol Austin*** BA, MSW, PhD	(403) 220-5946
Co-Investigators:	Susan Wagner, RN, MN	(306) 966-6244
	Sharon Warren, MSc, PhD	(780) 437-4510
	John Church, MA, PhD	(780) 492-9054

What Is the Purpose of the Study?

The purpose of the LINCS Research Program is to develop an understanding of how continuity of care can be improved through policy and management decisions in the health care system. This study has been reviewed and approved by the University of Saskatchewan Behavioral Research Ethics Board.

In this part of the LINCS Research Program we would like to learn about how the Partnership Agreement between the Saskatoon Health Region and St. Paul's Hospital was developed and implemented to integrate services.

What Will Happen?

Your name has been provided as a senior leader who was involved in the development and/or implementation of the Partnership Agreement. We would like the opportunity to interview you about your views and experiences with the implementation of the Partnership that formed the basis for integrating the goals and activities of the Saskatoon Health Region and St. Paul's Hospital.

Your interview will be tape-recorded with your consent so that any points of clarification are not missed.

Your interview will be transcribed and you will have an opportunity to review the written transcript of your interview and make any changes before it is analyzed. A researcher from the LINCS team may meet with you to make sure that the LINCS team has interpreted your responses correctly.

How Much Time Will Be Taken?

The interview will take approximately 1 to 1.5 hours.

Benefits From Participating

As a respondent in this interview you have an opportunity to share your contributions and views about this process.

Are There Any Risks?

There are no known risks from being in this research study.

Participation in This Study

You are being asked to participate in this study because you are knowledgeable about the development and/or implementation for the Partnership Agreement between the Saskatoon Health Region and St. Paul's Hospital.

Researchers in the LINCS team will respect your personal choice if you feel that you would prefer not to participate and it is not necessary for you to give a reason if you with to discontinue this interview at any time..

Privacy and Confidentiality

Your name will not appear in this study, but your position title may be used in the research reports. Only the researchers will have access to the tapes and the information transcribed from the interviews.

Because your position title may be used in the research reports that result from this study, it may be possible for a knowledgeable reader to infer your identity. However, every effort will be made to ensure that anonymity is retained.

The transcripts from your interview will be kept in a locked drawer for five years. The consent forms will be kept in another locked drawer for five years. They will then be destroyed.

The findings from this study may be published or presented at a conference.

A secondary analysis of the data from these interviews will be conducted by graduate student, Karen Macmillan, BScN, to complete requirements for her Master of Nursing thesis. The plan for this analysis will be presented to an Ethics Committee for approval before the analysis commences.

Questions?

If you have any question about any aspect of this study, you may contact Professor Donna Lynn Smith (780) 492-9544, who is the Principle Investigator of the LINCS Research Program or Catherine Jeffery (306) 655-5594, who is the liaison person for the Saskatoon Health Region for the LINCS Research Program.

Concerns?

If you have any concerns about any aspect of this study, and would prefer not to discuss them with a researcher, you may contact Dr. Kathy Kovacs Burns, Research Administration, Faculty of Nursing, at (780) 492-5991. This office has no affiliation with the study investigators.

CONSENT FORM

Phase I: Program Leaders' Interviews

Study Title: LINCS Research Program – Phase I		
Principal Investigator:	***Donna Lynn Smith*** RN, MEd, CPsych, CHE	(780) 492-9544
Co-Principal Investigator:	***Carol Austin*** BA, MSW, PhD	(403) 220-5946
Co-Investigators:	Susan Wagner, RN, MN Sharon Warren, MSc, PhD John Church, MA, PhD	(306) 966-6244 (780) 437-4510 (780) 492-9054

	YES	**NO**
Do you understand that you have been asked to participate in a research study?		
Have you read and received a copy of the attached information sheet?		
Do you understand the benefits and risks involved in taking part in this research study?		
Have you had an opportunity to ask questions and discuss the study?		
Do you understand that you are participating in the study because of the position you previously held or currently hold within the Saskatoon Health Region or St. Paul's Hospital?		
Has the issue of confidentiality been explained to you?		
Do you understand that the position titles of participants may be mentioned in published reports, and that this may make it possible for a knowledgeable reader to infer you identity?		
Do you understand who will have access to the information you provide and how it will be stored and protected?		

This study was explained to me by:

Researcher:____

Printed Name:____

Date: ____

I agree to take part in the part of the study indicated:

Signature of Research Participant:__________________________

Witness (if available):__________________________________

Printed Name:____

Date:____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Researcher:____

Printed Name:____

Date: ____

CONFIRMATION OF STATEMENTS

The information that you provided in your interview has been complied and reviewed by the team and is attached for your review.

We would like to take this opportunity to review the attached summery for any discrepancies or errors and to ensure the accuracy of the information.

If any changes need to be made, please feel free to contact Professor Donna Lynn Smith at (780) 492-9544; otherwise, the statements as outlined will be used in the research.

Thank you for your time.

Date: ***Signature of approval from participant***

Date: ***Signature of researcher***

APPENDIX D:

VALUES-BASED LEADERSHIP THEMES

Vision, Values, and Mission

Author	Date	Title
Bennis, W.	1999	The End of Leadership Exemplary Leadership Is Impossible Without Full Inclusion, Initiatives and Cooperation of Followers
Bruhn, J. G.	2004a	The Ethic of "The Organizational Good": Is Doing the Right Thing Enough?
Collins, J.	2001	Level 5 Leadership: The Triumph of Humility and Fierce Resolve
Cummings, G., Hayduk, L., & Estabrooks, C.	2005	Mitigating the Impact of Hospital Restructuring on Nurses: The Responsibility of Emotionally Intelligent Leadership
Dunham-Taylor, J.	2000	Nurse Executive Transformational Leadership Found in Participative Organizations
Gosling, J., & Mintzberg, H.	2003	The Five Minds of a Manager
Gragnolati, B. A., & Stupak, R. J.	2002	Life and Liberty: The Power of Positive Purpose
Howatson-Jones, I. L.	2004	The Servant Leader
Kuczmarski, S., & Kuczmarski, T.	1995	Values-Based Leadership
Leatt, P., & Porter, J.	2003	Where Are the Healthcare Leaders? The Need for Investment in Leadership Development
McEnroe, J. J.	1995	Portrait of Outstanding Leaders
McNeese-Smith, D. K., & Crook, M.	2003	Nursing Values and a Changing Nurse Workforce: Values, Age, and Job Stages
O'Toole, J.	1995	Leading Change: The Argument for Values-Based Leadership
Pendleton, D., & King, J.	2002	Values and Leadership
Perra, B. M.	2001	Leadership: The Key to Quality Outcomes
Schwartz, R. W., & Tumblin, T. F.	2002	The Power of Servant Leadership to Transform Health Care Organizations for the 21st-Century Economy
Shirey, M.	2005	Ethical Climate in Nursing Practice
Strack, G., & Fottler, M. D.	2003	Spirituality and Effective Leadership in Healthcare: Is There a Connection?

(table continues)

Author	Date	Title
Tourangeau, A., & McGilton, K.	2004	Measuring Leadership Practices of Nurses Using the Leadership Practices Inventory
Trofino, J.	1995	Transformational Leadership In Health Care
Valentino, C. L.	2004	The Role of Middle Managers in the Transmission and Integration of Organizational Culture

Ethics and Integrity

Author	Date	Title
Bennis, W.	1999	The End of Leadership Exemplary Leadership Is Impossible Without Full Inclusion, Initiatives and Cooperation of Followers
Bruhn, J. G.	2004a	The Ethic of "The Organizational Good": Is Doing the Right Thing Enough?
Gragnolati, B. A., & Stupak, R. J.	2002	Life and Liberty: the Power of Positive Purpose
Howatson-Jones, I. L.	2004	The Servant Leader
Kuczmarski, S., & Kuczmarski, T.	1995	Values-Based Leadership
McEnroe, J. J.	1995	Portrait of Outstanding Leaders
McNeese-Smith, D. K., & Crook, M.	2003	Nursing Values and a Changing Nurse Workforce: Values, Age, and Job Stages
O'Toole, J.	1995	Leading Change: The Argument for Values-Based Leadership
Pendleton, D., & King, J.	2002	Values and Leadership
Perra, B. M.	2001	Leadership: The Key to Quality Outcomes
Shirey, M.	2005	Ethical Climate in Nursing Practice
Valentino, C. L.	2004	The Role of Middle Managers in the Transmission and Integration of Organizational Culture

Service and Inspiration

Author	Date	Title
Bennis, W.	1999	The End of Leadership: Exemplary Leadership Is Impossible Without Full Inclusion, Initiatives, and Cooperation of Followers
Bruhn, J. G.	2004b	Leaders Who Create Change and Those Who Manage It: How Leaders Limit Success
Cummings, G., Hayduk, L., & Estabrooks, C.	2005	Mitigating the Impact of Hospital Restructuring on Nurses: The Responsibility of Emotionally Intelligent Leadership
Dunham-Taylor, J.	2000	Nurse Executive Transformational Leadership Found in Participative Organizations
Gosling, J., & Mintzberg, H.	2003	The Five Minds of A Manager
Howatson-Jones, I. L.	2004	The Servant Leader
Kuczmarski, S., & Kuczmarski, T.	1995	Values-Based Leadership
Leatt, P., & Porter, J.	2003	Where Are The Healthcare Leaders? The Need for Investment in Leadership Development
McNeese-Smith, D. K., & Crook, M.	2003	Nursing Values and a Changing Nurse Workforce: Values, Age, and Job Stages
O'Toole, J.	1995	Leading Change: The Argument for Values-Based Leadership
Pendleton, D., & King, J.	2002	Values and Leadership
Perra, B. M.	2001	Leadership: The Key to Quality Outcomes
Schwartz, R. W., & Tumblin, T. F.	2002	The Power of Servant Leadership to Transform Health Care Organizations for the 21st-Century Economy
Secretan, L.	2004	Inspire! What Great Leaders Do
Shirey, M.	2005	Ethical Climate in Nursing Practice
Strack, G., & Fottler, M. D.	2003	Spirituality and Effective Leadership in Healthcare: Is There a Connection?
Trofino, J.	1995	Transformational Leadership in Health Care

Legacy

Author	Date	Title
Bennis, W.	1999	The End of Leadership: Exemplary Leadership Is Impossible Without Full Inclusion, Initiatives, and Cooperation of Followers
Collins, J.	2001	Level 5 Leadership: The Triumph of Humility and Fierce Resolve
Kuczmarski, S., & Kuczmarski, T.	1995	Values-Based Leadership
O'Toole, J.	1995	Leading Change: The Argument for Values-Based Leadership
Pendleton, D., & King, J.	2002	Values and Leadership
Secretan, L.	2004	Inspire! What Great Leaders Do
Schwartz, R. W., & Tumblin, T. F.	2002	The Power of Servant Leadership to Transform Health Care Organizations for The 21st-Century Economy
Shirey, M.	2005	Ethical Climate in Nursing Practice

APPENDIX E:

CARE GROUPS

St. Paul's Hospital

- Palliative Care Services
- Emergency and Pre-Hospital Services
- Renal Services
- Food Services
- Pharmacy Services

Saskatoon District Health

- Addiction Services
- Continuing Care and Geriatric Services
- Mental Health Services
- Public Health Services
- Rehabilitation Services
- Surgical Services
- Women's Reproductive and Children's Services

Joint Management

- Family Services
- Diagnostic and Laboratory Services
- Medicine Services

Highlights
St. Paul's Hospital – Saskatoon District Health Joint Service Management Partnership, April 18, 1996